EXHIBIT 1

CNH / UAW

GROUP BENEFIT PLANS

2005 NEGOTIATIONS

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CNH America LLC
Group Insurance Plan
Effective 2005

CNH America LLC
GROUP BENEFIT PLAN

2005 Negotiations

This Group Benefit Agreement is made effective with the 2005 negotiations and developed through collective bargaining between the CNH America LLC, hereafter referenced as CNH and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

Term of Agreement

- The term runs from 12:01 A.M. March 21, 2005, and expires at 11:59 P.M. on April 30, 2011.
- The benefits described herein are applicable for the term of the Agreement as referenced above and as agreed to by the Company and the Union.

The Life, Accidental Death and Dismemberment, and Survivor Income Benefit coverage described herein are provided under a Group Policy issued to CNH, and are subject to the terms and conditions of the Group Policy. Each employee may request to review the policies in their local Human Resources department. The medical, dental, vision, accident and sickness, layoff disability, and long term disability plans are provided by CNH on a self-insured basis.

For the period May 3, 2004 through March 31, 2005 the medical, dental, vision and hearing program plan design features which were in place on May 2, 2004 will continue with the following exceptions. Effective December 31, 2004 the Wellmark PPO Plan and the DentaCare Plan are eliminated. Effective April 1, 2005 active employees and those employees on A&S, will be required to contribute towards the medical plan per the contribution schedule contained in the Company's Settlement Agreement dated March 16, 2005. Effective April 1, 2005 the plan design elements contained herein become effective, unless an alternate date is specifically noted in a particular section. Additionally contributions for medical plan participation will be modified each January 1 beginning January 1, 2006.

- Effective April 1, 2005 retirees and surviving spouses of retirees who retired from the Company on or after December 1, 2004 as well as any then current and future LTD participants, will be required to contribute towards the medical plan per the contribution schedule contained in the Company's Settlement Agreement dated March 16, 2005. Effective April 1, 2005 the plan design elements contained therein become effective unless noted with an alternate date. Additionally retiree, surviving spouse and LTD participant contributions for medical plan participation will begin April 1, 2005 and will be modified each January 1 beginning January 1, 2006. Group insurance benefits for employees who retired before December 1, 2004 are not covered by this group insurance plan.

Plan changes which are indicated as being effective on a specific date will be effective as of such date provided the employee is actively at work on such date or the last regularly scheduled working day prior thereto. If not actively at work on such dates, the changes will become effective upon the employee's return to active work unless otherwise noted.

Special provisions applicable to employees hired on or after May 14, 1998, will be described as applicable in this booklet.

I. BENEFITS FOR EMPLOYEES

A. **Life Insurance (for employees hired prior to May 14, 1998)**

Effective:	January 1, 2005	$46,000

Life Insurance (for employees hired on or after May 14, 1998)

Effective:	January 1, 2005	$22,000

Monthly Installment Payout of Group Life Insurance - Total & Permanent Disability -

An employee, who becomes totally and permanently disabled after attaining two or more years of seniority but prior to attaining age 65, and who does not qualify for a Normal, Regular Early, or Disability Pension under the Pension Plan, may elect to receive his life insurance benefits in fifty monthly installments at the rate of $20 per month for each $1,000 of life insurance in lieu of a death benefit.

The first of such installments shall be payable on the later of:

1) the first day of the month coincident with or next following the date the employee is no longer eligible to receive Weekly Disability Benefits and Monthly Long-Term Disability Benefits;

2) the first day of the month following submission of required proof of such disability.

If the employee dies while monthly installments are being paid, the remaining installments will be paid in a lump sum of not less than $500. If an employee dies after all the installments have been paid, the beneficiary will receive $500.

In the event an employee returns to active employment with the Company after receiving payments of his life insurance in installments, the amount of insurance in effect after the return to work shall be the amount to which the employee is then entitled under the Plan then in effect. The amount of insurance in effect for further payment of monthly installments in the event of future disability shall be reduced by the total amount of the installment payments previously made.

Continuation of Life Insurance Benefits - Total & Permanent Disability
If an employee does not elect the monthly installment payout option, Life Insurance coverage in the amount listed below will be continued:

If you die	Effective on and after January 1, 2005, provided that the employee is at work on that date*
With 5 or more years of service	
Before age 65	46,000
Age 65 but less than 66	34,500
Age 66 or older	23,000
With less than 5 years of service	No Benefits

The continuation of coverage will continue if the employee:

1) Is totally disabled while life insurance coverage is in effect.

2) Under age 65 when the total disability commences.

3) The employee continues to be totally disabled until the date of death.

The life insurance benefit will be payable when:

1) The total disability continued for at least nine months.

2) The employee continues to provide proof that the total disability continues. The employee will not be required to provide proof of continued disability more than once a year.

*Coverage for employees hired on or after May 14, 1998 shall be a proportionate amount of the levels provided below.

The employee may be required to undergo an independent medical examination by a doctor of the insurance company's choice, at no cost to the employee. The employee will not be required to undergo the examination more than once a year.

If the employee does not provide proof of total disability, when required, the life insurance benefits will cease.

An employee shall be deemed to be totally and permanently disabled if he is unable, due to physical or mental incapacity, to perform any job for which the employee is qualified for by reason of education, training or experience.

B. **Accidental Death & Dismemberment Insurance**

	Employees Hired Prior to May 14, 1998	Employees Hired On or After May 14, 1998
Effective: January 1, 2005	$23,000	$11,000

1) If an employee is injured in an accident, Accidental Death or Dismemberment Benefits will be paid:

(a) if the accident occurs while covered for Accidental Death or Dismemberment Benefits; and

(b) if that accident is the sole cause of the injury; and

(c) if that injury is the sole cause of a Covered Loss; and

(d) if that loss occurs not more than two years after the date of that accident.

2) The maximum benefit for all losses caused by all injuries which an employee sustains in one accident is $23,000 or $11,000, based on hire date.

3) In the event an employee dies as the result of a work incurred accident for which Worker's Compensation Benefits are payable by CNH, the amount payable is $46,000. For employees hired on or after May 14, 1998, the amount payable is $22,000.

4) Table of Covered Losses & Benefit Amounts

Covered Losses (Subject to Exclusions)	Benefits Amount	
	Employees Hired Prior To May 14, 1998	Employees Hired On or After May 14, 1998
Loss of Life	$23,000	$11,000
Loss of sight of both eyes	$23,000	$11,000
Loss of both hands	$23,000	$11,000
Loss of both feet	$23,000	$11,000
Loss of one hand or one foot, together with loss of sight of one eye	$23,000	$11,000
Loss of one hand	$11,500	$5,500
Loss of one foot	$11,500	$5,500
Loss of sight of one eye	$11,500	$5,500

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

5) Exclusions

Each of the above losses is not a Covered Loss if it in any way results from, or is caused or contributed to by:

(a) Physical or mental illness, diagnosis of or treatment for the illness; or

(b) An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or

(c) Suicide or attempted suicide; or

(d) Injuring yourself on purpose; or

(e) Hernia, no matter how or when sustained;

(f) A war, or a warlike action in time of peace.

C. Survivor Income Benefit Insurance **(for employees hired prior to May 14, 1998)**

The Survivor Income Benefit consists of two elements:

(a) Transition Survivor Benefits which may be payable for 24 months.

(b) Bridge Survivor Benefits which may be payable after the 24 months of Transition Survivor Benefits.

1) Transition Survivor Benefits shall be:
Effective January 1, 2005, for persons who become eligible on or after that date:

(a) $600.00 for each month there is no eligible survivor in the class who is eligible for an unreduced benefit under Social Security; and,

(b) $300.00 for any month in which any eligible survivor in the class is eligible for an unreduced benefit under Social Security.

The order in which survivors qualify for benefits is as follows:

Class 1 - Spouse -- If he or she was married to the employee for at least one year immediately prior to the date of death.

Class 2 - Child or Children -- If unmarried and under 21 years of age at the time each monthly benefit is payable.

Class 3 - Parent – If, during the calendar year preceding the year of death the deceased provided at least 50% of the parent's support.

(c) The surviving spouse of an employee who dies as the result of work incurred accident or illness for which Worker's Compensation Benefits are payable by the Company, will be entitled to continue Medical, Dental, and Vision coverage at the applicable participant contribution level. Such coverage shall cease on the surviving spouse's remarriage, attainment of age when such surviving spouse is eligible for Medicare or upon death.

The coverage during such period will include children who would have been covered as dependents of the employee had he not been deceased. If the spouse's coverage ceases because of death or remarriage, coverage for such children will continue for as long as the children would have continued if the spouse had not died or remarried, at the applicable participant contribution level.

(d) The transition survivor benefit will be payable on the first day of the calendar month after the death of the employee. This payment will continue until the earliest of:

(1) the date 24 transition survivor benefits have been paid; or,

(2) the date there are no eligible survivors left in any class of survivors.

2) Bridge Survivor Income Benefits shall be $600.00 per month, effective January 1, 2005, for persons who become eligible on/or after that date.

(a) A surviving spouse will be eligible for Bridge Benefits if the surviving spouse is at least 45 years old; or if the spouse's age at the time of the employee's death, plus the years of service of the deceased employee, total 55 or more.

(b) Twelve (12) months of Medical, Dental, and Vision Coverage will be provided to Surviving Spouses eligible for Bridge Benefits for a death occurring on or after January 1, 2005 at the applicable participant contribution level. (Such time shall count toward COBRA.)

The Coverage for such period will include children who would have been covered as dependents of the employee.

(c) The first Bridge Survivor Benefit will be payable on the first day of the calendar month after 24 transition survivor benefits have been paid. The Bridge Survivor Benefit will continue until the earliest of:

(1) The date the surviving spouse remarries or dies.

(2) The date the surviving spouse reaches –

a. age 62 and one month.

b. any lower age at which full benefits become payable under the Federal Social Security Act.

D. **Optional Contributory Life Insurance**

In addition to the basic plan of non-contributory life insurance, employees have the option of choosing an additional amount of contributory life insurance under one of the plans shown below.

Plan	Amount of Life Insurance
A	$ 5,000
B	$10,000
C	$15,000
D	$20,000
E	$30,000
F	$40,000
G	$50,000

The cost for the life insurance will be the amount established by the insurance company and the premium is paid monthly via payroll deduction.

Employees who are on layoff or receiving weekly Accident & Sickness benefits may elect to continue coverage for a period of time equal to the basic life extension, up to one year by paying the appropriate monthly contribution.

After electing an amount of optional contributory life insurance, an employee cannot change to a higher or lower amount unless the employee makes a written request to the Insurance Company to do so. In addition, an employee will be required to submit evidence of good health before the life insurance can be increased to a higher amount.

The Accidental Death & Dismemberment coverage, total and permanent disability provisions which apply to basic non-contributory life insurance do not apply to the contributory coverage.

E. **Weekly Accident & Sickness Benefits**

If an employee becomes, while actively employed and eligible for Weekly Accident & Sickness Benefits, totally disabled due to non-occupational illness or injury and is under the care of a physician licensed to practice medicine, the amount of Weekly Benefits provided by the following schedule shall be paid to the employee each week during the period the employee is so disabled and under such treatment, for the duration stated in this section.

Accident & Sickness Benefits

Employee Average Hourly Rate Earnings of: For disabilities commencing after April 1, 2005	
Less than 10.45	$250
10.45 less than 10.80	255
10.80 less than 11.15	260
11.15 less than 11.50	265
11.50 less than 11.85	270
11.85 less than 12.20	275
12.20 less than 12.55	280
12.55 less than 12.90	285
12.90 less than 13.25	290
13.25 less than 13.60	295
13.60 less than 13.95	300
13.95 less than 14.30	305
14.30 less than 14.65	310
14.65 less than 15.00	315
15.00 less than 15.35	320
15.35 less than 15.70	325
15.70 less than 16.05	330
16.05 less than 16.40	335
16.40 less than 16.75	340
16.75 less than 17.10	345
17.10 less than 17.45	350
17.45 less than 17.80	355
17.80 less than 18.15	360
18.15 less than 18.50	365
18.50 less than 18.85	370
18.85 less than 19.20	375
19.20 less than 19.55	380
19.55 less than 19.90	385
19.90 less than 20.25	390
20.25 less than 20.60	395
20.60 less than 20.95	400
20.95 less than 21.30	405
21.30 less than 21.65	410
21.65 less than 22.00	415
22.00 less than 22.35	420
22.35 less than 22.70	425

22.70 less than 23.05	430
23.05 or more	435

1) Totally disabled means that because of a sickness or an injury that an employee cannot do his job; or the employee cannot do any job which they are fit for by reason of education, training or experience.

2) Weekly Accident and Sickness Benefits shall not be payable while the employee is retired under a pension plan of the Company, to which the Company has contributed, and is receiving pension benefits from that pension plan.

3) Effective for disabilities commencing after April 1, 2005, the calculation of employee's "Base Hourly Rate" to determine the benefit amount for Weekly A&S benefits and Long Term Disability Benefits will be continued on the present calendar quarter schedule. The calculation in all instances will include: shift premium and the other items which were included under the 1998 contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be $4.00 accumulated under prior agreements for employees hired before May 2, 2004. No other COLA is included. Further, Average Hourly Rate will be based on average earnings in the 3rd calendar quarter of 2004 until the end of the 2nd quarter of 2005.

Before conversion to CCICS (not in a CCICS application)

Schedule A & C employees receive benefit levels based on their Schedule rates (non-CCICS indirect) for the quarter.
Schedule B employees receive benefit levels based on their incentive earnings (SHP earnings as under the 1995 Agreement) for the quarter.
New hires receive benefit levels based on their Schedule rates (day rate or direct non-CCICS).

After conversion to CCICS (if participating in a CCICS application)

Schedule A&C employees receive benefit levels based on the CCICS rates Schedule A&C for the quarter.
Schedule B-RCPL eligible employees who are receiving their RCPL due to working in a CCICS application will receive benefit levels based on their RCPL earnings for the quarter. Non-RCPL eligible employees who are working direct (formerly SHP paid work) will receive benefit levels based on the CCICS payment for the quarter. New hires receive benefit levels based on their Schedule rates (day rate, direct non-CCICS) or CCICS rate.

4) Weekly Benefits will continue during total disability for up to a maximum of 52 weeks for employees who have at least 52 weeks seniority.

5) Employees who have less than 52 weeks seniority when first disabled will receive benefits for a period equal to their seniority when first disabled rather than a full 52 weeks. However, benefits may continue beyond a period equal to seniority up to the full 52 weeks while such an employee is hospitalized or drawing Worker's Compensation Benefits.

6) Weekly Accident and Sickness Benefits are not payable for disabilities resulting from occupational illness or injury. The Company shall, however, supplement Worker's Compensation weekly benefits in order to provide a total benefit level which is equivalent to the Weekly A&S indemnity rate including such payment during the Worker's Compensation initial waiting period.

7) Weekly Accident and Sickness Benefits shall not be payable for any day the employee receives Holiday Pay.

8) In the event an employee returns from an occupational disability absence and is assigned to a lower rated job because of an occupational disability with a resulting loss of pay, his benefit payments, should he again become disabled, will be based on the highest hourly wage rate the employee received within the last six months prior to the time the occupational injury or disability occurred. Benefits shall be determined in the aforementioned manner until six months after the employee recovers from his disability and is physically capable of performing a job as highly rated as the job he had prior to the occupational disability.

9) Weekly Sickness and Accident Benefits will be paid commencing with the first day of total disability due to accident or the eighth day of total disability due to illness, except that benefits will commence with the first day of hospitalization occurring during such period of disability or with the day on which a covered surgical procedure is performed without hospitalization for which the physician's fee is $25 or more.

10) The waiting period for A&S Benefits for employees receiving treatment for substance abuse as provided in the Plan, will be eliminated, provided the Company will have the right to designate the approved facility for treatment of repeat confinements.

11) In the event of a contested claim for Worker's Compensation benefits, the employee shall receive an amount of money equal to his current Weekly A&S rate. The employee will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in favor of the employee which duplicates a payment previously made by the Company, will be returned to the Company by the employee, or deducted from any final settlement the Company may be required to make.

12) One-fifth of the Weekly A&S Benefit amount will be paid for each work day an employee is absent due to total disability.

13) Disabilities resulting from pregnancies will be considered for Weekly A&S Benefits and Long Term Disability Benefits as other disabling illnesses or injuries.

14) If an employee is granted a leave of absence due to a clinically anticipated disability based on the natural course of the employee's diagnosed condition, upon medical certification satisfactory to the Company from the employee's attending physician that the employee is totally disabled, A&S benefits will be payable.

15) Weekly accident and sickness benefits are payable for a maximum of 52 weeks for any one continuous period or disability which is due to one or more causes. Successive periods of disability which are due to same cause or a related cause will be considered one continuous period unless separated by a period of at least 90 days.

16) The amount of weekly accident and sickness benefits for a continuous period of disability is the amount in effect at the time that period of continuous disability starts. The amount of weekly accident and sickness benefits will be reduced by the amount an employee receives from any fund, other insurance or other source of disability or income benefits provided by state or governmental law.

17) Employees on layoff and no longer receiving any layoff benefits under section F will not re-establish eligibility for A&S benefits until they have been recalled and completed 30 days of active service.

18) The following guidelines will be used by the Company to implement the reduction of Accident and Sickness benefits by Social Security disability insurance benefits.

(a) As early as the thirteenth but no later than the twentieth week of disability, depending upon the initial prognosis on the claim, an Employee will be notified of the eligibility requirements and advised to apply for Social Security Disability Insurance Benefits (DIB).

The Employee will be advised that, effective with the payment for the twenty-sixth week of disability, Accident and Sickness (and Long Term Disability) benefits computations will presume eligibility for DIB except that if, prior to such twenty-sixth week, the Employee files for DIB and completes a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination, he shall receive unreduced Accident and Sickness (or Long Term Disability) benefit payments while he is otherwise eligible. Further, the Employee will be instructed that, if his physician anticipates that the Employee's disability will not extend beyond twelve months, his physician should complete a statement indicating such a prognosis. Where such a statement is provided, a reduction of Accident and Sickness (or Long Term Disability) benefits, based on presumed eligibility for DIB, will not be instituted in the twenty-sixth week of disability.

If during the ensuing period of disability it becomes apparent that either (1) through deterioration of the Employee's condition; or (2) prolongation of the recovery period, that he will not return to work for a prolonged period, he will be requested to file for DIB and complete reimbursement and authorization forms.

(b) In the twenty-fourth week of disability, any employee whose physician has not completed the statement referenced in "(a)" above, will be again advised to apply for DIB if he has not done so and instructed to complete a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination.

Failure to (1) apply for DIB; (2) complete a reimbursement agreement; or (3) complete the authorization form will result in the suspension of an amount of Accident and Sickness (or Long Term Disability) benefits equal to the presumed amount of DIB (commencing at the 16th week) until the Employee provides satisfactory proof that he has applied for DIB, completed a reimbursement agreement and an authorization form. The Employee also will be advised that he may authorize release of information in the Accident and Sickness (and Long Term Disability) benefit claim files to the Social Security Administration.

(c) Upon receipt of an initial determination of disallowance of DIB, a notice will be sent instructing the Employee to (1) file a request for reconsideration, within two weeks of the date of the notice; and (2) complete an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination.

Failure to either (1) request such reconsideration within such time period; or (2) complete the authorization form will result in suspension of an amount of Accident and Sickness (or Long Term Disability) benefit payments equal to the presumed amount of DIB until the Employee provides satisfactory proof that such request has been filed and the authorization form has been completed.

(d) Upon receipt of a reconsideration determination of disallowance, the Employee will be encouraged to file for a hearing before an administrative law judge of the Social Security Administration. If the Employee files for such a hearing, he will be requested to complete another authorization form as referenced in "(c)" above.

(e) In the event of a reconsideration determination denying DIB, and provided any subsequent review does not reverse such decision, the Employee will not be required to repay any Accident and Sickness (or Long Term Disability) benefits otherwise payable, unless such denial of DIB resulted from the Employee's refusal to accept vocational rehabilitation. Where such denial occurs, the Employee is obligated to repay Accident and Sickness (and Long Term Disability) benefits in an amount equal to the amount of DIB to which he would otherwise have been entitled for the same period or periods of disability.

(f) Upon receipt of a notice of award of DIB, any overpayment of Accident and Sickness (or Long Term Disability) benefits caused by the retroactive award of DIB is to be repaid. The amount of the overpayment will be based on the actual amount of such award.

(g) In the event of a DIB award resulting from a reconsideration or hearing before an administrative law judge, the amount of Accident and Sickness (and Long Term Disability) benefits overpayment will be reduced by an amount equal to any attorney fees associated with the award, provided that (1) the Employee makes such repayment within thirty days of the date the Employee is notified of the amount to be repaid; and (2) such reduction applies only to attorney fees associated with the successful appeal of a denial of DIB and includes only that portion of the attorney's fee associated with the period of time the Employee was entitled to receive Accident and Sickness (and Long Term Disability) benefits; and (3) such reduction for such attorney fees may not exceed 25 percent of the overpayment. Attorney fees for services prior to denial of the initial application for DIB will not reduce the amount of overpayment.

(h) An Employee age 65 or older may be entitled to Old-Age Benefits as early as the first day of total disability. No reduction of Accident & Sickness benefits shall be made until the Employee provides evidence that he is receiving Old-Age Benefits (through authorization of information disclosure by the Social Security Administration or otherwise). If requested, such evidence shall be provided by such an Employee.

(i) In the event an Employee receives an initial determination of disallowance of DIB, all amounts of Accident & Sickness Benefits withheld will be paid to the Employee unless the Employee was denied DIB for failure to accept vocational rehabilitation or for not filing for DIB within the period of time specified by the Social Security Administration as necessary for DIB to commence at the first of the sixth month of disability.

(j) When the company mails the initial notice to the Employee requesting that the Employee apply for DIB, a copy of such initial notice will be mailed to the Union's Local Insurance Representative, if any, of the facility at which the Employee works.

F. **Lay-Off Disability Benefits (Sub-Plan)**

1) Eligibility - An employee shall be eligible for Lay-Off Disability Benefits if he meets all of the following conditions:

(a) He is on a qualified lay-off under the Supplemental Unemployment Benefit Plan;

(b) *He was eligible for a benefit under the Sub-Plan immediately prior to the time he became disabled, or, if not so eligible, was employed by another employer at such time;

(c) He is totally disabled by disease or accidental injury so as to be unable to perform any job for the company;

(d) He is under the care of a physician;

(e) He is not eligible for Sickness & Accident Benefits or Long Term Disability Benefits.

* This requirement shall not apply to an employee who is ineligible for a regular benefit under the SUB-Plan because of failure to meet the requirements of the UC earnings test.

2) Amount - The weekly Lay-Off Disability Benefit shall be equal to the weekly Accident & Sickness Benefit applicable to the employee. For each week that the employee receives a Lay-Off Disability Benefit. Lay-Off Disability Benefits shall be reduced by the amount of any disability benefit the employee received for the same week or portion thereof under a plan of another employer.

3) Period of Payment - Payment of Lay-Off Disability Benefits shall commence on the first day of disability, or the day immediately following the last day for which a benefit is payable under the SUB-Plan, whichever is later. Payment shall cease upon the earlier of:

(a) Exhaustion of all full SUB benefit;

(b) Recovery from total disability;

(c) Recall from layoff;

(d) Employees otherwise eligible for Lay-Off Disability Benefits will continue to receive the Benefit until exhaustion of all full SUB benefit under the cancellation provisions of the Plan. After SUB benefit eligibility has been exhausted, employees otherwise eligible will continue to receive Lay-Off Disability Benefits for a period of up to 52 weeks from date of lay-off in the amount of the applicable State U.C. benefit or $150, whichever is greater per week.

4) Special Provisions

(a) If an employee is recalled from lay-off while receiving Lay-Off Disability Benefits and immediately qualifies for Accident & Sickness Benefits, the maximum number of weeks for which such Accident & Sickness Benefits are payable shall be reduced by the number of weeks for which Lay-Off Disability benefits were paid.

(b) If an employee ceases to be totally disabled and remains on a qualifying lay-off under the SUB Plan, Lay-Off Disability Benefits shall be payable for the remaining days in the same week (as defined in the SUB Plan) for which he does not receive a benefit under the SUB Plan.

(c) An employee may waive irrevocably any right he may have to receive Lay-Off Disability Benefits with respect to any period of disability by completing a waiver form furnished by the Company. No Lay-Off Disability Benefits shall be payable for the period covered by such waiver.

G. **Long-Term Disability Benefits**

1) An Employee with two or more years seniority and who is eligible for Weekly Accident & Sickness Benefits and who, as of the date of expiration of the maximum number of weeks for which he is entitled to receive Weekly Accident & Sickness Benefits and during a continuous period of disability thereafter, is totally disabled so as to be unable to engage in any gainful occupation or employment for which he is reasonably qualified by education, training or experience, receives Long Term Disability for the period described in this section.

Long Term Disability Benefits
Employees Average Hourly
Rate Earnings of:
Period Commencing: January 1, 2005

	Less Than 10 Years	10 Years or More
Less than 10.45	$890	
10.45 less than 10.80	910	
10.80 less than 11.15	930	
11.15 less than 11.50	950	
11.50 less than 11.85	970	
11.85 less than 12.20	990	
12.20 less than 12.55	1010	
12.55 less than 12.90	1035	
12.90 less than 13.25	1055	
13.25 less than 13.60	1075	
13.60 less than 13.95	1100	1225
13.95 less than 14.30	1120	1245
14.30 less than 14.65	1140	1265
14.65 less than 15.00	1155	1285

15.00 less than 15.35	1175	1305
15.35 less than 15.70	1200	1330
15.70 less than 16.05	1220	1350
16.05 less than 16.40	1240	1370
16.40 less than 16.75	1260	1390
16.75 less than 17.10	1280	1410
17.10 less than 17.45	1300	1435
17.45 less than 17.80	1325	1455
17.80 less than 18.15	1345	1475
18.15 less than 18.50	1365	1495
18.50 less than 18.85	1385	1515
18.85 less than 19.20	1405	1540
19.20 less than 19.55	1430	1560
19.55 less than 19.90	1450	1580
19.90 less than 20.25	1470	1600
20.25 less than 20.60	1490	1620
20.60 less than 20.95	1510	1645
20.95 less than 21.30	1535	1665
21.30 less than 21.65	1555	1685
21.65 less than 22.00	1575	1705
22.00 less than 22.35	1595	1725
22.35 less than 22.70	1615	1745
22.70 less than 23.05	1635	1765
23.05 or more	1655	1785

2) The Long Term Disability Benefit shall be reduced by:

(a) Primary Social Security Benefit

(b) Retirement benefits provided under the CNH U.S. Pension Plan

(c) Worker's Compensation Benefits

(d) Disability benefits under any State or Government Plan

(e) Disability benefits under any other Company-sponsored Plan

(f) The amount of Widow's benefit available under Social Security.

3) Effective for disabilities commencing after January 1, 2005, the calculation of employee's "Base Hourly Rate" to determine the benefit amount for Weekly A&S Benefits and Long Term Disability Benefits will be continued on the present calendar quarter schedule. The calculation will include the employee's base hourly rate (Schedule A, B, or C), incentive earnings (for Schedule B employees only), RCPL (if eligible), CCICS rates (if applicable), shift premium and other items which were included under the prior contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be $4.00 accumulated under the prior agreements for employees hired before May 2, 2004. No other COLA is included.

4) In the event the employee makes application and is denied benefits under the above specified programs, the Long Term Disability Benefits shall not be reduced. Failure of the employee to make application shall, however, cause the Long Term Disability Benefits to be reduced by an amount which would have been payable except for the failure to apply.

5) The reduction of benefits for which the employee is eligible under Worker's Compensation laws or other laws providing benefits for occupational injury or disease, including lump sum settlements, shall exclude specified allowances for loss, or one hundred percent (100%) loss of use of a bodily member.

6) Long Term Disability benefits will not be payable for any period during which the employee engages in any gainful occupation. However, an employee will not be ineligible for Long Term Disability Benefits because of work which is determined to be primarily for training under a recognized program of vocational rehabilitation. During the first two years Long Term Disability Benefits are payable the earnings from such rehabilitative employment shall not be deducted from the Long Term Disability Benefits. Thereafter, such earnings shall be deducted.

7) Long Term Disability benefit computations shall presume eligibility for Social Security Disability insurance benefits, and if the employee has ten (10) years of service, total and permanent disability pension benefits. Deductions from Long Term Disability benefits will be made on this basis unless the person receiving benefits provides satisfactory evidence that these benefits were applied for and denied; provided however, that a reduction shall be made in the amount equal to Social Security disability insurance benefits that would have been payable except for refusal to accept vocational rehabilitation services.

8) In determining the amount by which Long Term Disability benefits shall be reduced, the monthly equivalent of benefits paid on a weekly basis shall be computed by multiplying the weekly benefit rate by 4.33. In the case of lump sum settlements under Worker's Compensation, the reduction shall be equal to the amount of Worker's Compensation benefit to which the employee would have been entitled under applicable law had there been no lump sum payment, but not to exceed in total the amount of the settlement.

9) The cumulative total number of months during any previous periods of eligibility for Long Term Disability Benefits, regardless of whether for the same or related disabling condition, reduces the maximum number of monthly benefit payments for which the individual is otherwise eligible should Long Term Disability benefits again commence.

10) Long Term Disability Benefits are not payable for any period of disability resulting from...

(a) intentionally self-inflicted injury or where a contributing cause was the commission of a felony;

(b) war or act of war, or due to any act of international armed conflict, or conflict involving the armed forces of any international authority.

11) Long Term Disability Benefits will continue until:

(a) If the disability commences prior to age 60...

1. Up to the earlier of

a. For a period equal to the employee's seniority on the date he became disabled less one year; or,

b. The day before the employee turns age 65.

(b) If the disability commences after age 60 but prior to age 63...

1. Up to the earlier of

a. The date the employee receives sixty months of LTD benefits; or,

b. The day before the employee turns age 70.

(c) If the disability commences after age 63 but prior to age 65...

1. The date the employee receives 24 months of LTD benefits.

(d) If the disability commences after age 65...

1. The date the employee receives 12 months of LTD benefits.

12) Increases in Social Security, Worker's Compensation, pension or disability benefits provided under any Government Plan occurring after the initial date LTD benefits are payable will not be offset against LTD benefits. Redeterminations of pension or Social Security benefits which result in greater benefits will be offset.

13) Employees on layoff and no longer receiving any layoff benefits under section F, will not re-establish eligibility for long term disability until they have been recalled and completed 30 days of active service.

II. BENEFITS FOR EMPLOYEES & DEPENDENTS MEDICAL BENEFITS

CNH provides affordable, comprehensive health care through local Medical Networks of physicians and hospitals to employees regardless of when hired, and their eligible dependents.. The network is available in a majority of locations. This is a Preferred Provider Option (PPO) managed care program. Employees may choose to be treated in or out of the network each time they need medical treatment.

Employees and dependents who receive care from network providers receive a higher level of benefit than those that receive care from a provider who is not a member of the network.

In the case of an employee who does not reside in a network location, the non-network plan will be the employee's plan.

A. Summary

The Medical Network is made up of physicians, hospitals and other health care professionals who have contracted with the claims administrator to provide appropriate treatment at predetermined rates. CNH does not control which hospitals and physicians participate, and is not a party to any agreements between the administrator and the specific hospital or physician.

The network is available in designated zip code areas. Eligible employees will be notified where the network is available each year at enrollment.

Each time treatment is needed, the participant may choose to be treated in the network or out of the network.

Receive a higher level of benefits if treatment is received from a physician or hospital in the medical network.

1) Medical Plan Contributions
Contributions for Medical coverage for active employees, employees on layoff, employees on A&S and other similarly situated employees beginning April 1, 2005 will be the same contributions required by the CNH non represented employees for enrollment in the National PPO Plan (based upon enrollment category). Effective January 1, 2006 and January 1, 2007 the contribution levels will be adjusted in the same manner as the non represented employees for the same enrollment category. Beginning January 1, 2008 the required contributions will be set at 15% of the total plan cost projected for each plan year based upon UAW covered employee plan experience. Plan cost is comprised of projected claim and administrative costs for each specific category of coverage (i.e. single, dependent, spouse and family categories). These contributions will be taken from the first four paychecks per month on a generally equal basis and will be taken on a before tax basis.

Contributions for Medical coverage for retirees (who retire on or after December 1, 2004) and surviving spouses and LTD participants' coverage from April 1, 2005 through December 2007, will be the same contributions required from the CNH non represented retirees for enrollment in the National PPO Plan for single coverage, (the family rate will be two times the single rate, two-tier enrollment). Beginning in January 2008 the required contributions will be adjusted to reflect a formula whereby the increase in total plan cost

from the prior year (2007) projected to 2008 (using UAW participants experience) will be prorated so the retiree contributions will be adjusted to pick up 60% of the projected additional total plan cost for 2008 and each subsequent year.

Further information about contributions and contribution increases is contained in the Letters of Understanding section of this booklet.

2) Opt-Out Credit For Active Employees
Effective April 1, 2005 active employees who elect no Medical, Dental *and* Vision coverage, and are not covered as a dependent under another CNH plan, will be eligible to receive a yearly credit of $1,000. This credit will be added to employees pay, divided equally between 48 pay periods. This credit will be taxable and will not constitute earnings for any benefit purposes. This opt-out credit will be prorated for 2005 due to the new benefit plan effective April 1st. There is no opt-out credit available for inactive employees, retirees, surviving spouses or LTD participants. Further, new employees are not eligible for opt-out credit until they have completed their intial waiting period for medical enrollment, plus the period of the enrollment window (30 days after your eligibility date).

CNH America LLC
Group Insurance Plan
Effective 2005

B. **National PPO Medical Plan Covering Employees effective April 1, 2005**

	In-Network *	*Out-Of-Network*** *Subject to R&C*
Annual Deductible	$200 per person/ $400 per family	$500 per person/ $1,000 family
Annual Out of Pocket Maximum Base pay under $40,000*** Base pay $40,000 - $59,999 Base pay $60,000 - $79,999 Base pay $80,000 or higher	 $1,000 per person/ $2,000 per family $1,500 per person/ $3,000 per family $2,000 per person/ $4,000 per family $2,500 per person/ $5,000 per family	 $2,000 per person $3,000 per person $4,000 per person $5,000 per person
Coinsurance	85% after deductible (deductible does not apply to routine doctor office visits or preventive care)	65% after deductible
Allergy Tests and Treatments	Allergy Injections: $20 copayment each visit	65% after deductible
Chiropractic (Medically necessary)	$20 copayment per visit	65% after deductible
Durable Medical Equipment including Necessary replacement, or repairs *(Crutches, Wheelchairs, Hospital Bed, Respirator, including oxygen and other gases, and their administration) (also includes 1 hearing aid per 36 months).*	85% after deductible Subject to a calendar year maximum of $2,500 (Combined in and out of network)	65% after deductible. Subject to a calendar year maximum of $2,500 (combined in and out of network)
Consumable Medical Supplies *(e.g. Ostomy supplies, catheters, etc.)*	85% after deductible	65% after deductible
Emergency Ambulance	85% after deductible	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible

	In-Network *	*Out-Of-Network** Subject to R&C*
Emergency Care	85% after deductible	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible
Emergency Care (Physician's office)	$20 copayment per visit	Network level benefit if care meets administrator's definition of emergency. Otherwise, 65% after deductible
External Prosthetic Devices including Necessary replacement	85% after deductible. Subject to a calendar year maximum of $3,000 (combined in and out of network)	65% after deductible. Subject to a calendar year maximum of $3,000 (combined in and out of network)
Necessary repairs to External Prosthetic Devices	85% after deductible	65% after deductible
Family Planning: Infertility Office Visit	$20 copayment per visit	65% after deductible
Family Planning: Infertility Surgical Treatment	85% after deductible	65% after deductible. Covered for testing and diagnosis only, *No coverage for surgical procedures*
Family Planning: Sterilization Tubal Ligation	85% after deductible	65% after deductible
Family Planning: Sterilization Vasectomy	85% after deductible	65% after deductible
Gynecological Exam	$20 copayment per visit; one well woman exam per calendar year	65% after deductible for illness and injury only. Well-woman exam and related expenses are not covered
Home Health Care *(Includes necessary services and supplies supplied and billed by home healthcare agency)*	85% after deductible	65% after deductible
Hospice Care: Inpatient Facility Outpatient *(Maximum of five sessions per week)*	 85% after deductible 85% after deductible	 65% after deductible 65% after deductible

	In-Network *	*Out-Of-Network*** *Subject to R&C*
Inpatient Hospital Service *(Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and x-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services)*	85% after deductible. No reasonable limit on charges billed by the network facility; pre-certification of hospitalization and continued stay required	65% after deductible if you precertify the hospitalization and continued stay.
Inpatient Professional Services *(e.g. physician services, surgeon, assistant surgeon and anesthesiologist)*	85% after deductible	65% after deductible
Lab/X-ray (Outpatient)	85% after deductible	65% after deductible
Mammogram	$20 copayment. If age 35 and over, one exam per calendar year (more frequently if Necessary)	65% after deductible If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if Necessary)
Maternity - Obstetrician Services	$20 copayment for initial visit. No copayment for subsequent services including prenatal visits, delivery and postnatal visits.	65% after deductible
Other Outpatient Services *(e.g. chemotherapy and radiation treatment)*	85% after deductible; No Reasonable limit when billed by a network facility other than a physician's office	65% after deductible
Outpatient Hospital Services *(e.g. hemodialysis and preadmission testing)*	85% after deductible. No Reasonable limit when billed by a network facility.	65% after copayment
Outpatient Short-term Rehabilitation *(Includes occupational therapy, physical therapy and speech therapy)*	85% after deductible. Subject to annual maximum of 60 sessions (outpatient) (combined in and out of network)	65% after deductible Subject to a annual maximum of 60 days sessions (out-patient) (combined in and out of network)
Outpatient Specialty Physician Services	$20 copayment per visit	65% after deductible
Outpatient Surgical Services *(Includes operating and recovery room, services and supplies)*	85% after deductible (no Reasonable limit when billed by the network facility)	65% after deductible

	In-Network *	*Out-Of-Network*** *Subject to R&C*
Primary Care Physician *(Includes adult medical care, adult physical exams, child medical care, routine immunizations and injections, vision and hearing screening, well-child and well-baby care)*	$20 copayment per visit	65% after deductible for injury or illness only. Routine physical exams, immunizations or well-child and well-baby care *are not included*
Skilled Nursing Facility	85% after deductible No reasonable limit on charges billed by the network facility	65% after deductible
Treatment for TMJ	Medical treatment only 85% after deductible	Medical treatment only 65% after deductible
Mental Health/ Substance Abuse Treatment Inpatient • Treatment must be certified to receive benefits • Covered expenses include those billed by the treatment facility, including residential treatment, halfway houses, group homes and day hospital treatment programs.	85% of covered charges after you meet the deductible.	65% after deductible
Mental Health/Substance Abuse Outpatient • Treatment must be certified to receive benefits. • Covered expenses include those billed by the treatment facility; including residential treatment, halfway houses, group homes and day hospital treatment programs.	$20 copay/visit	65% up to 20 visits/yr
Maximum Lifetime Benefit	No Limit	$500,000

* In-Network benefits subject to applicable copay, then covered 100% up to day/visit limits, as applicable. Copays do not count toward meeting deductibles and out-of-pocket maximums.

** Out-of-Network benefits are subject to Reasonable and Customary (R&C) limits.

***These amounts also apply to individuals who become eligible for LTD benefits from CNH and those individuals who were hired prior to May 14, 1998 and retire on or after December 1, 2004 and their surviving spouses and eligible dependents.

	Coverage	*Where to Purchase*
Prescription Drugs**** Note: Walgreen's Health Initiatives network must be used. There is no out-of-network benefit unless in an emergency or residing outside the United States. ****Plus cost difference if generic is available.	**Employees hired before May 2, 2004:** **Retail up to 30 day supply:** • Generic: $10 • Formulary: $30**** • Non-Formulary: $50 **** 2007 & 2008, copays will be $10/$35/$55 respectively 2009 – 2011, copays will be $10/$40/$60 respectively **Mail order 30 – 90 day supply:** • Generic: $20 • Formulary: $60**** • Non-Formulary: $100**** 2007 & 2008, copays will be $20/$70/$110 respectively 2009 – 2011, copays will be $20/$80/$120 respectively **Employees hired on or after May 2, 2004:** Plan pays 70% of covered charges after you pay separate annual deductible of $50 per person, subject to these participant minimums and maximums **Retail up to 30 day supply:** • Generic: $5 min/$200 max • Formulary: $15 min/$300 max**** • Non-Formulary: $30 min/no max.**** **Mail order 30 – 90 day supply:** ◦ Generic: $10 min/$400 max ◦ Formulary: $30 min/$600 max**** ◦ Non-Formulary: $60 min/no max****	Retail: Participating Network Pharmacies Mail Order: Through WHI Mail Order service.
Lifestyle drugs (such as drugs for obesity control, E.D., and smoking cessation)	Not covered, but can be purchased through the network at a discount price.	Participating Network pharmacies

Note: Prescription deductibles, copays and coinsurance do not apply toward meeting medical deductibles or out-of-pocket maximums.

C. Non-Network Medical Plan

Where no Network Medical Plan is available, or for Retirees (or their surviving spouses) who retired on or after December 1, 2004 who are Medicare-eligible, or LTD participants who are Medicare-eligible, health care is provided through the Non-Network Plan effective April 1, 2005 as summarized below.

Annual Deductible	$250 per person $500 per family
Annual Out of Pocket Maximum	
• Base pay under $40,000*	$1,500 per person/$3,000 per family
• Base pay $40,000 - $59,999	$2,000 per person/$4,000 per family
• Base pay $60,000 - $79,999	$2,500 per person/$5,000 per family
• Base pay $80,000 or higher	$3,000 per person/$6,000 per family
(Includes deductible)	

Note: All coverages are based on reasonable and customary charges for the services rendered.

Allergy Tests and Treatments	80% after deductible
Ambulance	80% after deductible
Chiropractic (Medically necessary) maximum)	80% after deductible ($300 calendar year
Durable Medical Equipment Including Necessary Replacement or repairs *(Crutches, Wheelchairs, Hospital Bed, Respirator, including oxygen and other gases, and their administration)* (includes 1 hearing aid per 36 months)	80% after deductible Subject to calendar year maximum of $2,500
Consumable Medical Supplies *(e.g. ostomy supplies, catheters, etc.)*	80% after deductible
Emergency Care	80% after deductible; if admitted to hospital, must certify with 48 hours.
Emergency Care (Physician's office)	80% after deductible
External Prosthetic Devices Including Necessary replacement	80% after deductible. Subject to calendar year maximum of $3,000
Hospice Care: Outpatient *(Maximum of five sessions per week)*	80% after deductible; precertification required; must meet definition of hospice

Inpatient Hospital Service (*Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and x-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services*)	80% after deductible the hospitalization and continued stay must be precertified
Inpatient Professional Services (*e.g. physician services, surgeon, assistant surgeon and anesthesiologist*)	80% after deductible if not billed by hospital
Lab/X-ray (Outpatient)	80% after deductible
Mammogram	100% for well exams. If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if necessary) 80% after deductible for treatment of illness or injury.
Other Outpatient Services (*e.g. chemotherapy and radiation treatment*)	80% after deductible
Outpatient Hospital Services (*e.g. hemodialysis and preadmission testing*)	80% after deductible
Outpatient Short Term Rehabilitation (*physical therapy, speech therapy, occupational therapy*)	80% after deductible; annual maximum of 60 sessions
Outpatient Surgical Services (*Includes operating and recovery room, services and supplies*)	80% after deductible
Pap Smear	100% for well exams; 1 exam per year if 18 years old or older. 80% after deductible for treatment of illness or injury.
Routine Physical	Not covered
Immunizations	100% no deductible
Outpatient Doctor's Office Visits	80% after deductible
Skilled Nursing Facility	80% after deductible

Mental Health/Substance Abuse Treatment *(includes inpatient and outpatient treatment)*	All treatment must be precertified to receive benefits Inpatient-80% after deductible Outpatient-80% after deductible - Maximum 30 visits per year
Prescription Drugs** Note: Walgreens Health Initiatives network must be used. There is no out-of-network Benefit unless in an emergency or Residing outside the United States. ****Plus cost difference if generic is available.	**Employees hired before May 2, 2004:** **Retail up to 30 day supply:** Generic: $10 Formulary: $30**** Non-Formulary: $50 **** 2007 & 2008, copays will be $10/$35/$55 respectively 2009 – 2011, copays will be $10/$40/$60 respectively **Mail order 30 – 90 day supply:** Generic: $20 Formulary: $60**** Non-Formulary: $100**** 2007 & 2008, copays will be $20/$70/110 respectively 2009 – 2011, copays will be $20/$80/$120 respectively **Employees hired on or after May 2, 2004:** Plan pays 70% of covered charges after you pay separate annual deductible of $50 per person, subject to these participant minimums and maximums **Retail up to 30 day supply:** Generic: $5 min/$200 max Formulary: $15 min/$300 max**** Non-Formulary: $30 min/no max.**** **Mail order 30 – 90 day supply:** Generic: $10 min/$400 max Formulary: $30 min/$600 max**** Non-Formulary: $60 min/no max****
Maximum Lifetime Benefits	$1,000,000

- **These amounts also apply to individuals who become eligible for LTD benefits from CNH and those individuals who were hired prior to May 14, 1998 and retire on or after December 1, 2004 and their surviving spouses and eligible dependents.**

** **Effective January 1, 2007 Prescription coverage is eliminated for all Retirees, Surviving Spouses and LTD participants and/or their covered dependents who are or become eligible for Medicare.**

D. Additional Plan Provision - National PPO and Non-Network Medical Plans

1) Home Health Care

The Plan provides continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized (subject to applicable plan limits).

The following home health care services are provided under the program:

(a) Nursing Care

Embodies all medically necessary nursing care which may be readily provided within the patient's home as part of the total physician-directed, prescribed plan of treatment. It includes coordinating the patient's health care program by evaluating and channeling appropriate information to other participants of the health care team, administering medication, assisting with rehabilitative or terminal care, instructing and guiding the patient and family in procedures resulting in greater self-sufficiency and other essential nursing services and professional care of the degree of intensity provided for by the Program. Examples of these services would be changing dressings, administering injections, teaching self-administration of insulin and other injectables, evaluating the patient's condition and advising the patient's personal physician of the patient's progress within the treatment plan.

(b) Physical Therapy

Includes all therapy deemed essential to the treatment of the patientwhen determined and prescribed by the attending physician and the Home Care Agency. Emphasis is on the restorative and rehabilitative services which may easily be provided within the patient's home, making the patient more self-sufficient. This includes implementing, teaching, evaluating and supervising, and when necessary, it also includes exercise regimens for strengthening and maintaining muscles, gait training, prosthetic device training and instructing a responsible family participant in routine exercises tomaintain the patient's strength and range of motion.

(c) Occupational Therapy

Occasionally, if appropriate, an occupational therapist may provide therapy services such as evaluating the vocational possibilities of the patient , teaching house-hold activities commensurate with the disability, teaching substitution for non-functioning parts of the body or stimulating the patient's interest in purposeful activity.

(d) Speech Therapy

Speech Therapy consists primarily of correcting or restoring the patient's vocal pattern following illness or injury.

(e) Social Services Guidance

Focus is on evaluating the personal, emotional, social and environmental circumstances related to or resulting from the patient's illness and correcting those factors which may further complicate or hinder favorable responses to medical treatment, as requested and directed by the patient's personal physician.

(f) Dietary Guidance

Includes evaluation and recommendations relevant to diet regulations and menu preparations for the patient by nutritionists and dieticians and instructing the patient and/or a responsible family participant to understand the dietary and nutritional requirements within the medical treatment plan.

(g) Home Health Aide Service

This service is intended for patients whose families are unable to provide this service for them and is provided only if the agency determines that the particular patient could not be on home care without such service. A home health aide must be in the employ of the home care agency and have received special training in the care of the sick. The aide gives non-professional care to the patient as is necessary when performed upon medical recommendation and under appropriate supervision of the home care nurse. Duties may include such personal care as feeding the patient, helping the patient in and out of bed, meal preparation, getting the children off to school and various other patient related duties. Benefits are payable only when the service is performed in conjunction with professional service. Eight (8) hours of home health aide service, either fragmented or continuous, constitutes one (1) home care visit. Services provided by or secured by the family or another local social agency are not benefits.

(h) Medical supplies, drugs, and laboratory and x-ray services.

The home health care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision; or, by a social worker, nutritionist or dietician under the supervision of the PCP.

The PCP or other attending physician must certify the necessity for the care and the administrator must approve the care. The care will not be covered if:

- Provided by a person who ordinarily resides in the home or by an immediate family participant.
- Consists of transportation services.
- Required certification and/or approval have not been obtained.
- Is not included in an approved home health care program.

2) Hospice Care

The Plan provides physical, psychological, social and spiritual care for dying persons with six months or less to live, and for their families.

Hospice benefits services are provided by physician-supervised professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on call basis. Bereavement services are available to the family. The following categories of care will be provided (subject to applicable plan limits):

(a) nursing care provided by or under the supervision of a registered nurse;

(b) medical social services provided be a social worker under the direction of a physician;

(c) physician services;

(d) counseling services provided to the patient, family participants and/or other persons caring for the patient at home;

(e) general inpatient care provided in a hospice inpatient unit;

(f) medical appliances and supplies;

(g) physical, occupational and speech therapies;

(h) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(i) respite care;

(j) bereavement counseling;

(k) care required in a nursing home with hospice support; and

(l) home health aide services.

The PCP or other attending physician must certify that the individual is expected to die within six months. The administrator must approve the hospice program of care based on patient and family need.

3) Annual Deductible

Each dependent enrolled in the Plan must meet separate per person deductible each year based upon network or non network plan as applicalbe.. Two or more covered dependents may help the family meet the family deductible.

The deductible starts over each January 1. There is no carryover from year to year.

An expense must be covered by the Plan to be credited to your deductible.

If two or more dependents are injured in the same accident:
The family must meet only one per person deductible for all the covered dependents who were in the accident.

4) Copayments

Participants make a payment each time they receive treatment (usually $20 for physician's services) in the network. Participants pay significantly more if they receive treatment out of the network.

5) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum limits the amount participants pay for their share of covered expenses including deductibles. The annual out-of-pocket maximum is set each year based on your base pay rate the preceding December.

After reaching the out-of-pocket maximum, the Plan will pay the remaining covered expenses at the applicable percentage for that year, including deductibles.

Each dependent enrolled in the Plan must meet a separate per person out-of-pocket maximum each year in the amount shown in the applicable schedule. Two or more covered dependents may help the family meet the family out-of-pocket maximum, if applicable.

The out-of-pocket maximum starts over each January 1. There is no carryover from year to year. The out-of-pocket provision does not apply to prescription drug expenses.

6) Lifetime Maximum

National PPO Plan (Out-of-Network Services) - $500,000 per person.

The lifetime maximum does not apply to covered treatment in the network.

Non-Network Plan - $1,000,000 per person.

7) Hospital Precertification

Precertification is a confirmation of the benefits the Plan will pay when participants are admitted to a hospital.

Treatment selection (i.e. in-network or out-of-network) will determine which steps the participant must follow.

- Participants must precertify inpatient hospital admissions to receive a regular benefit reimbursement from the Plan.
- Non-Emergency Hospitalization: Participants must precertify before they are admitted.
- Emergency Hospitalization: The participant or their doctor must certify within 48 hours after the admission.
- If not precertified, benefits payable will be reduced $1000 or the coinsurance will be reduced 100%, whichever is less. This cannot be applied to the annual deductible or out-of-pocket maximum.

If the participant is admitted to an out-of-network hospital by an out-of-network physician the participant should precertify before the scheduled admission date.

Allow at least seven days for the precertification to be processed.

If the admission is for the delivery of a baby, certify at anytime during the pregnancy, the participant should provide the due date and then notify the precertification administrator within 48 hours after the mother is admitted. A medical counselor will work with the physician and hospital to certify the stay for benefit coverage and handle discharge planning.

The precertification administrator should be contacted as soon as possible after admission to an out-of-network hospital in an emergency situation.

The following information should be provided:

- Patient's name and birth date,
- Employee's name and Participant ID or Social Security number,
- Planned admission or surgery date,
- Physician's name, phone number and address,
- Hospital name, phone number and address, and,
- Reason for admission or procedure.

The participant, their physician and the hospital will be notified when an admission has been authorized for benefits.

If the hospitalization is authorized, the administrator will certify the length of stay.

Then, if the participant elects to remain in the hospital beyond this established length of stay, the participant or their representative must contact the administrator to request authorization for benefits to continue.

If the hospitalization is not authorized for benefits, the participant may file an appeal with the administrator if they do not agree with its decision.

8) Preexisting Conditions

Pre-existing condition restrictions do not apply to individuals covered by the plan.

9) Special Situations - Network Medical Plan

a) Urgent Care In the Network Service Area

An urgent situation is not life threatening but requires immediate medical attention – such as a sprain, bone break, fever, sore throat or minor burns.

A network pediatrician should be consulted for guidelines for children under six months of age.

Participants will receive in-network benefits for urgent care from any licensed physician or urgent care facility by following these steps:

If possible, the participant should contact Customer Services before the participant goes to the facility.

This will ensure they receive in-network benefits. If the participant cannot contact Customer Services before they go to the facility, Customer Services should be contacted within 48 hours after treatment.

Use a network provider to receive in-network benefits. If outside your normal care area – contact Customer Service to locate a network provider.

The administrator's Medical Director will determine whether the treatment was urgent and qualifies for in-network coverage. If the treatment was urgent, charges will be reimbursed at the in-network benefit level less the applicable copayment. The participant will be eligible for out-of-network coverage if in-network benefits do not apply.

The participant should receive follow-up care when they return home.

If there is an urgent need for follow-up care, Customer Services should be contacted to request authorization in advance.

If admitted to the hospital, the participant must call the precertification administrator within 48 hours and follow his or her instructions to make sure they receive the in-network level of benefits.

b) Emergency Care In the Network Service Area

An emergency is a life-threatening illness, or an injury that requires immediate medical attention. Apparent heart attacks, severe bleeding, loss of consciousness and severe or multiple injuries are all examples of emergencies.

If possible, Customer Services should be contacted before the participant goes to the emergency facility.

This will ensure they receive in-network benefits. If the participant cannot contact Customer Services before they go to the emergency facility, they should contact Customer Services within 48 hours after emergency treatment whether or not they are hospitalized.

Participants should ask for an itemized bill and receipt marked clearly as"Emergency Services." and call Customer Services for instructions on how to receive reimbursement.

The administrator's Medical Director will review the emergency treatment and determine if it qualifies for in-network coverage. If the treatment was due to an emergency, charges will be reimbursed at the in-network benefit level less the applicable copayment. The participant will be eligible for out-of-network coverage if in-network benefits do not apply and they must file a claim form for reimbursement.

c) Emergency Hospital Admission In the Network Service Area

Call to precertify admission to an out-of-network hospital.

If a participant chooses to stay in the out-of-network hospital rather than be transferred, the participant must obtain authorization for out-of-network coverage. The participant must call Customer Services at the telephone number on the back of the ID card. If the participant does not call for authorization, the participant's share of covered expenses will be 100% of covered hospital expenses up to $1,000 (maximum penalty).

d) Urgent or Emergency Care Out of the Network Area

For emergency or non-emergency treatment, the participant must contact Customer Services at the number listed on the I.D. card.

Customer Services will tell the participant if a Medical Network is available in the area in which they are traveling. If so, the participant must go to a network provider to receive in-network benefits.

If a network is not available, and immediate care, is needed, the participant should go to any physician.
The participant should pay the usual fee and submit the bill to Customer Services. The participant should contact Customer Services within 48 hours of receiving the care. If Customer Services confirms that immediate medical attention was necessary, the participant will receive in-network benefits. If not, expenses will be processed for out-of-network benefits.

e) Guest Privileges

Your covered dependent may receive in-network benefits by using the providers in the travel network if:
- The employee lives in a PPO Network area,
- The employee is enrolled in the National PPO Plan,
- Their dependent lives outside your home PPO Network service area, and will be living in that area for at least 90 days, and
- The dependent receives treatment from a provider in travel Network.

No special application is necessary.

f) Transitional Care

Transitional care will be available to individuals who at the time of initial entry into the Network Plan suffer from a medical condition for which the maintenance of the current attending physician is necessary for the well being of the patient, then the patient may continue to utilize the attending physician for the specific condition for a specific limited period of time and receive network benefits. The types of conditions which would fall into this category would be acute cases where there is a specified end date to the course of treatment. This would include, but is not limited to, certain types of post operative care, radiation therapy , chemotherapy, pregnancy, terminal conditions where life expectancy is 12 months or less, etc.. The Network Administrator will be responsible for reviewing transitional care requests. In the event a dispute exists regarding the applicability of transitional care, a mutually agreeable third party physician will determine this applicability.

E. National PPO and Non-Network Medical Plans: Expenses Not Covered

- Acupuncture therapy.
- Artificial aids, such as:
  - Arch supports
  - Contact lenses
  - Corrective Orthopedic Shoes
  - Dentures
  - Over-the-counter elastic stockings, garter belts and corsets
  - Eyeglass lenses and frames, and
  - Wigs (except the plan will cover one(1) wig per lifetime following chemotherapy, and one (1) wig each 36 months for individuals diagnosed with alopecia).
- Medication or devices utilized for the prevention of pregnancy.
- Any treatment of teeth, gums or any oral surgery, unless it is as a result of an accident, or is due to a covered medical condition.
- Custodial care.
- Education therapy for learning disabilities.
- Fees for replaced blood or blood product.
- In-vitro fertilization.
- Artificial means of conception.
- Normal cosmetic therapy or surgery (and any complications thereof).
- Obesity control programs.
- Organ donation fees paid for a donated organ.
- Personal or comfort items.
- Private room or private-duty nurse (unless Necessary).
- Reversal of voluntary sterilization.
- Routine foot care (except approved orthotics).
- "Take-home" prescription drugs and over-the-counter drugs.
- In-network routine physical exams more than once per year.
- Transsexual surgery.
- Vocational rehabilitation.
- In connection with any eye examination and the purchase and fitting of eyeglasses and contact lenses; however, benefits will be payable for eyeglasses if they are prescribed as a direct result of: an injury which affects vision; a condition where the lens system of the eye has been destroyed; or, treatment of strabismus.

- In connection with cosmetic surgery, or any complications thereof (meaning plastic surgery, reconstructive surgery, or cosmetic surgery which improves, alters or enhances appearance, whether or not for psychological or emotional reasons) except to the extent Necessary to:
  - Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed:
  - As the result of a severe birth defect (including harelip or webbed fingers or toes), or
  - As a direct result of disease or surgery performed to treat a disease or injury
  - Repair an injury (which occurs while you or one of your dependents is covered under the Plan) in the calendar year of the accident which causes the injury or in the next calendar year.

In addition, treatements, services or supplies are not covered if they are:

- Not recommended and approved by a physician
- In connection with services rendered by an immediate family participant
- Not necessary as determined by the administrator for the treatment of the injury or illness
- In excess of the reasonable charge for the services performed or the material furnished, as determined by the administrator
- For health or check-up examinations, unless related to medical treatement for an injury or illness or except as expressly provided by plan provisions.
- Resulting from the treatment of:
  - Weak, strained or flat feet
  - Instability or imbalance of the foot
  - Any tgarsalgia, metatarsalgia or bunion, except surgery involving the cutting and suturing of tendons, ligaments and bones.
- Resulting from the treatment of toenails or superficial lesions of the foot including corns, calluses and warts, except for the removal of the nail root or matrix or the first palliative treatment of corns and calluses
- In connection with food supplements, minerals, vitamins or drugs that can be purchased without a written prescription (outpatient)
- In connection with speech therapy except to restore speech lost as a result of an accident or injury
- Education or training procedures for speech, hearing or vision
- Smoking cessation programs and treatment
- Incurred by a dependent child, retired employee or survivor who becomes entitled to plan benefits as an employee
- In connection with procedures, services, drugs and other supplies that are, as determined by the administrator experimental or still under clinical investigation by health professionals
- Related to therapy, supplies or counseling for sexual dysfunctions or inadequacies
- Related to sex change surgery or any treatment of gender identity disorders
- Related to or in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial
- In a hospital where there would be no charges made if coverage were not in force (e.g. in a federal, state or local government-operated facility)

- For accidental bodily injury arising out of or in the course of employment or where such treatment is payable under any workers' compensation or occupational disease act or law
- Resulting from injury or illness compensable under any law of government for its own civilian employees and their dependents, in which case the Coordination of Benefits (COB) rules apply
- Resulting from injury or illness caused by war, declared or undeclared, by any act of war, by service in the armed forces of any country or any civilian noncombatant unit serving with such forces or by participation in a riot
- Resulting from participation in or attempt to commit an assult or felony

Any person claiming benefits under this plan must furnish to the Administrator and authorize the Administrator to release such information as may be necessary to implement this provision.

The following procedures will be initiated for the processing of claims:

1) When a claim is denied, the following written information will be provided to the claimant:

   (a) The specific reasons for the denial.

   (b) Specific reference to the pertinent plan provision on which the denial is based.

   (c) A description of what type of additional information is needed to support a claim for payment of benefits.

2) Upon request, copies of all available material pertinent to the claim, will be given to the claimant or his authorized representative.

F. **Exclusions and Limitations For Mental Health and Substance Abuse**

Covered services do not include any of the following:

- Custodial care, educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- State hospital treatment except when determined by the administrator to be medically necessary.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation or therapy for educational or professional training or for investigational purposes relating to employment.
- Psychiatric or psychological examinations, testing or treatments that the administrator determines are not medically necessary, but which nevertheless may be required for purposes of obtaining or maintaining employment or insurance or pursuant to judicial or administrative proceedings.
- Academic education during residential treatment.
- Therapies which do not meet national standards for mental health professional practice, for example, Erhard/The Forum, primal therapy, bioenergetic therapy, crystal healing therapy.
- Experimental or investigational therapies.

- Court ordered psychiatric or substance abuse treatment unless the administrator determines that such services are medically necessary for the treatment of a condition included in the Diagnostic and Statistical Manual of Mental Disorder, revised, as amended to most recent version of DSM.
- Psychological testing, except where conducted for purposes of diagnosing a DSM Mental Disorder or when rendered in connection with treatment of such a Mental Disorder. All such testing requires preauthorization by the administrator.
- Charges for services, supplies or treatment that are covered charges under the medical portion of this Plan or other employer sponsored health care plan.
- Prescription drugs, except where dispensed by a Hospital or Residential or Day Treatment Program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program.
- Private duty nursing.
- Services to treat conditions that are identified by the DSM as not being attributable to a Mental Disorder (i.e. V Codes).
- Treatment of congenital or organic disorders, including, but not limited to Organic Brain Disease, Alzheimer's Disease, autism and mental retardation.
- Marriage counseling except when rendered in connection with treatment of a DSM Mental Disorder.
- Treatment for smoking cessation, weight reduction, obesity, stammering or stuttering.
- Inpatient treatment for eating disorders, unless the administrator determines that inpatient treatment is medically necessary for the treatment of another DSM Mental Disorder.
- Aversion therapy.
- Treatment for co-dependency, except when rendered in connection with treatment of a DSM Mental Disorder.
- Non-abstinence based on nutritionally based chemical dependency treatment.
- Treatment for sexual addiction.
- Treatment of chronic pain except when rendered in connection with treatment of a DSM Mental Disorder.
- Treatment or consultations provided via telephone.
- Services, treatment or supplies provided as a result of any worker's compensation law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof; or caused by the conduct or omission of a third-party for which the participant has a claim for damages or relief, unless the participant provides the administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the administrator.
- Treatment or consultations provided by the participant's parents, siblings, children, current or former spouse or domiciliary partner.
- Treatment for stress, except when rendered in connection with treatment of a DSM Mental Disorder.

G. Prescription Drugs
(Participants in the National PPO Medical Plan and Non-Network Plan)

If enrolled for any medical coverage through the National PPO Plan or Non-Network Plan, participants will automatically be enrolled in prescription drug.

Note: **Effective January 1, 2007 prescription drug coverage is eliminated for Retirees, Surviving Spouses, LTD participants and/or their covered dependents who are, or become eligible for Medicare.**

Walgreens Health Initiatives (WHI) administers all of CNH's prescription drug benefits and coordinates its mail order program through Walgreens Healthcare Plus. Participants will receive an ID card from WHI after enrollment. Participants present their ID card when you go to a participating pharmacy.

1) Retail Pharmacies

When they need a prescription drug for a 30-day supply or less, they take the prescription to a participating WHI network pharmacy participant.

Effective April 1, 2005, participants will be subject to specific plan provisions as detailed in the chart on the following page.

Participating WHI pharmacies include most but not all, locations of the following:
• Osco • Walgreens • CVS • Kmart • Wal-Mart, and • Many independent pharmacies.

When a new participant receives their WHI ID card in the mail, they will receive a directory of participating pharmacies in their area. They may also call the 800 number on their card and ask for a list of participating pharmacies in their area.

In order for the prescription drugs to be covered, the participant must either have the prescription filled at a participating network pharmacy (for 30-day supply or less), or use Walgreens Healthcare Plus mail order pharmacy (greater than a 30-day supply). *If the participant has a prescription filled any other way, it will not be covered by this plan.*

2) Mail Order Prescriptions

To obtain prescriptions for greater than a 30-day but up to a 90-day supply,participants use the mail order prescription drug program.

The program is provided by Walgreens Healthcare Plus.

Prescription Drugs	Coverage	Where to Purchase
Annual Deductible	Employees hired on or after May 2, 2004 only. $50 per person	
Coinsurance	Employees hired on or after May 2, 2004 only: Plan pays 70% of covered charges after deductible, subject to participant minimums/maximums below.	
Short-term Prescription (30-day supply or less)	Employees hired on or after May 2, 2004: • Generic: $5 min/$200 max • Formulary: $15 min/$300 max* • Non-Formulary: $30 min/$no max* Employees hired before May 2, 2004: • Generic: $10 • Formulary: $30* • Non-Formulary: $50 * 2007 & 2008, copays will be $10/$35/$55 respectively 2009 – 2011, copays will be $10/$40/$60 respectively	Participating WHI pharmacies
Long-term Prescription (30 to 90 day supply)	Employees hired on or after May 2, 2004: • Generic: $10 min/$400 max • Formulary: $30 min/$600 max* • Non-Formulary: $60 min/no max* Employees hired before May 2, 2004: • Generic: $20 • Formulary: $60* • Non-Formulary: $100 * 2007 & 2008, copays will be $20/$70/$110 respectively 2009 – 2011, copays will be $20/$80/$120 respectively	By mail through Walgreens Healthcare Plus
Lifestyle Prescriptions • Smoking cessation • Obesity control • E.D. • Cosmetic treatments • Infertility • Certain contractptives (abortive, emergency, implantable and injectable) • Diaphragms	Prescriptions for lifestyle drugs are not covered by the plan, but can be obtained at WHI network pharmacies at the full discounted network price.	Participating WHI pharmacies

*Plus cost difference if generic is available.

3) Prescriptions Requiring Prior Authorization for Benefits

Prior authorization is required by WHI to determine whether the following drugs will be approved for coverage:

- Betaseron
- Fertility agents
- Growth hormones, and
- Products used for cosmetic purposes, which are being considered for medical reasons..

In most cases, authorization can be handled by phone. Your physician should call 1-877-665-6609. If additional documentation is required, your physician will be instructed where to send a letter documenting the necessity for treating a covered health condition with such drugs.

4) Prescription drug expenses Not Covered:

- Any devices or appliances, such as orthotics and other nonmedical substances.
- Any vaccine administered for the prevention of infectious diseases.
- Antineoplastic agents except in oral dosage form.
- Any medication administered and entirely consumed in connection with care rendered in the home and office.
- Any charge for administration of covered drugs.
- Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order.
- More than a 30-day supply of a covered drug from a retail pharmacy.
- Any syringes and needles, except for disposable insulin syringes and needles prescribed with injectable insulin.
- Any drug requiring a prescription by State Law, but not Federal Law.
- Drugs for which the WHI ingredient cost plus the dispensing fee is either equal to or less than the copayment amount.
- Medications furnished on an inpatient or outpatient basis covered under any other plan providing group coverage for prescription drugs or insulin through a coordination of benefits provision, such as major medical, home health care benefits, or outpatient benefits.
- Excess retail costs charged by a WHI participating network pharmacy in the event it was not informed of your WHI coverage.
- Over-the-counter products are not covered unless specifically included, such as insulin.

H. Definitions

1) All Company-Sponsored Medical Plans

Alcohol or Other Drug Dependency Treatment Center

A facility which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a physician and also:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral, and
- Accredited as such a facility by the Joint Commission on Accreditation of Hospitals, and
- Licensed, certified, or approved as an alcohol or other drug dependency treatment center by any state agency having legal authority to so license, certify or approve.

Ambulatory Surgical Center

Any public or private establishment which:

- Has an organized staff of medical physicians, and
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, and
- Has continuous physician services and registered professional nursing services whenever a patient is in the facility, and
- Does not provide services or other accommodations for patients to stay overnight, and
- Is certified by the claims administrator Or the contracted network.

COBRA

Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Convalescent Facility

An institution (or distinct part of an institution) which:

- Is primarily engaged in and licensed to provide on the premises and for compensation from its patients skilled nursing services and physical rehabilitation services to convalescing patients, and
- Provides these services under the full-time supervision of an M.D., D.O. or R.N., and
- Maintains a complete medical record on each patient, and
- Is not other than incidentally a place for rest, for custodial care, for educational care, for the aged, drug addicts, alcoholics, or individuals who are mentally retarded or have mental disorders, and
- Has a written personal treatment plan for each patient which is prescribed and supervised by an M.D. or D.O., includes a diagnostic assessment of the patient and a description of the treatment to be rendered, and provides for follow-up assessments by or under the direction of the supervising M.D. or D. O., and

- Provides an ongoing quality assurance program which includes reviews by M.D.'s or D.O.'s who do not own or direct the facility.
- A convalescent facility will be treated the same as a hospital as the term used to determine benefits for physician services.

Cosmetic Surgery

Plastic surgery or reconstructive surgery which improves, alters or enhances appearance, except to the extent needed to:

- Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed as the result of a severe birth defect (including harelip or webbed fingers or toes) or as a direct result of a disease or surgery performed to treat a disease or injury, or
- Repair an injury, which occurs while the person is covered by the Plan, in the calendar year of the accident which causes the injury or in the next calendar year.

Covered Expense

A medical expense incurred under the direction of a physician, which is necessary for the treatment of an injury or sickness, not specifically excluded or otherwise limited under the Plan, not in excess of specified maximums, and is reasonable. This includes expenses for designated preventive diagnostic testing and designated immunizations and vaccinations.

Custodial Care

Routine services or supplies, including room and board and other institutional services, furnished to assist in daily living. Room and board will not be considered custodial care when combined with skilled nursing services and other necessary therapeutic services and supplies in accordance with generally accepted medical standards.
Such services and supplies must be provided in an institution which is approved by the claims administrator. Any medical treatment program which includes custodial care elements must be reasonably expected to substantially improve the covered person's medical condition in order to be covered.

Dependent Eligible dependents include your:

- Spouse, as defined by the laws of your state
- Unmarried children under age 19, including
  - Natural children
  - Legally adopted children
  - Stepchildren living with you, and
  - Children in your legal custody by court decree, who permanently live in your household, depend primarily on you for financial support, and live with you in a normal parent-child relationship
- Unmarried dependent children at least age 19 but under age 25 who
  - Have the same permanent, legal residence as you, and
  - Are primarily dependent upon you for maintenance and financial support, and
  - Are in regular, full-time attendance at an accredited secondary school, college, or university.
- Unmarried dependent children who are mentally or physically disabled as defined by the plan.

The plan administrator establishes whether a student is attending an accredited school using the reference book, *Accredited Institutions of Postsecondary Education*, published by the American Council on Education.

No other dependents are eligible for coverage, even if they live with the employee and depend on them for support.

Eligible dependents do not include:

- Your (or your spouse's) parents or grandparents, even if living with you and dependent upon you for support
- Your married children
- Your sister or brother
- Your grandchildren, unless they become your legal dependents by legal adoption or guardianship
- Your brother-in-law or sister-in-law
- Your stepchildren who do not live with you, unless you or your spouse are required to provide them with coverage under the terms of a divorce decree, or
- Your aunts, uncles or cousins.
- An eligible dependent child cannot be actively serving in the armed forces of any country.

Disabled Child Your unmarried, disabled child is eligible for continued medical coverage if the child is:

- Physically or mentally disabled
- Incapable of self-support upon reaching age 19 or 25 – when eligibility would otherwise end
- Unmarried, and
- Claimed as a dependent on your federal income tax return.

If you wish to continue coverage for a disabled child:
You must provide proof of the child's disability that is acceptable to the claims administrator within 30 days after your child reaches the age (19 or 25) when eligibility would otherwise end.

DRG Diagnostic Related Groups. Classifications to group inpatient cases by principal diagnosis and other relevant factors. The "DRG Amount" is a predetermined charge for each DRG as determined by applicable law (or regulations) or by the Claims Administrator.

Home Health Care A program for continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized. The necessity of the program must be certified by the attending physician and approved by the claims administrator. Services rendered under the program are skilled nursing care, home health services, paraprofessional nursing care, therapeutic services (physical or speech therapy), medical supplies, drugs, and laboratory and x-ray services. The care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision. The care will not be covered if:

- Not included in a claims administrator approved home health care program,
- Provided by a person who ordinarily resides in your home, or by an immediate family member,
- Provided by a social worker, or
- Consists of transportation services.

Hospice A centrally administered program of palliative and supportive services which provides physical, psychological, social and spiritual care for dying persons (who have six months or less to live as diagnosed and certified by the attending physician) and their families. Services are provided by a physician-supervised interdisciplinary team of professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on-call basis. Bereavement services are available to the family. Benefit approval for a hospice program of care is based on patient and family need.

Hospital

An institution which:

- Maintains permanent and full-time facilities for bed care of resident patients, and
- Has a physician in regular, full-time attendance, and
- Continuously provides 24-hour-a-day nursing service by registered nurses, and
- Primarily engages in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics or a place for drug addicts, and
- Operates lawfully in the jurisdiction in which it is located.

Medicare Allowable Charge

The charge which Medicare considers to be an appropriate reimbursement for charges made by providers other than hospitals.

Necessary

A service or supply is Necessary if it is for the diagnosis, care or treatment of a physical or mental condition and widely accepted professionally in the U.S. as effective, appropriate, and essential, based upon recognized standards of the health care specialty involved.

The Plan will not consider Necessary:

- Services rendered by a health care provider that do not require the technical skills of the provider, or
- Services and supplies furnished mainly for personal comfort or convenience of the covered person, any one who cares for the covered person, or any member of the covered person's family, or
- Services and supplies furnished because the covered person is hospitalized on a day when he or she could be diagnosed or treated while not hospitalized, or
- The part of the cost that exceeds that of any other service or supply which would be sufficient to diagnose and treat the physical or mental condition.

Outpatient Preadmission Test

A test performed in anticipation of hospital confinement if:

- The test is related to the problem for which hospitalization is required
- The test has been ordered by a physician after a condition requiring the confinement has been diagnosed and the hospital admission has been requested, and
- The test is done within seven days prior to the hospital admission.

Physician

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Chiropractic (D.C.)
- Doctor of Podiatry (D.P.M. or D.S.C.)
- Doctor of Dentistry (D.D.S. or D.M.D.)
- Doctor of Optometry (O.D.)

A physician for purposes of mental health and substance abuse treatment includes psychiatrist, psychoanalyst, psychologist, or other physician specializing in the treatment of substance abuse or mental health disorders. The physician must be licensed by the State in which the service is provided.
The physician must be licensed to perform a particular service which is covered by the Plan. The physician cannot be a member of a covered person's immediate family.

Prosthesis

- An artificial replacement body part that may be missing or defective as a result of surgical intervention, trauma, disease or developmental anomaly, or
- A device to aid or augment the performance of natural bodily functions.

Reasonable

The charge for a service or a supply which is the lower of the provider's usual charge or the prevailing charge in the geographic area where it is furnished – as determined by the Claims Administrator. The Claims Administrator takes into account the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility and the prevailing charge in other areas. The DRG amount will be considered the reasonable charge if a hospital or other facility is required by law to charge the DRG amount.

Spinal Manipulative Therapy

Manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position.

2) **Mental Health And Substance Abuse**

Certification or Certified

The decision by the administrator to certify treatment or proposed treatment as covered in accordance with this program and this Plan.

Covered Services

The Medically Necessary mental health or substance abuse care covered under this Program, except to the extent that such care is otherwise limited or excluded under this program or the Plan.

Emergency or Emergency Condition

A mental health or substance abuse condition determined by the administrator to require immediate medical diagnosis, attention or treatment in order to avoid a situation which could reasonably be expected to:

- Cause the participant or another person harm, or
- Jeopardize the participant's life or cause the participant to jeopardize the life of another person.

Level of Care

The intensity and/or magnitude of a mental health or substance abuse care treatment setting, treatment plan or treatment modality including, but not limited to:

- Acute care facilities
- Less intensive inpatient or outpatient alternatives to acute care facilities, such as residential treatment centers, group home or structured outpatient programs
- Outpatient visits, or
- Medication management.

Medically Necessary

A service or supply which the administrator has established for benefits determination purposes to be:

- Provided for and consistent with the symptoms or proper diagnosis and treatment for the specific participant's illness, disease or condition, and
- Not primarily for the convenience of the participant, the participant's family, or the provider providing the service, and
- The appropriate level of care that can safely be provided for the specific participant's diagnosed condition in accordance with both generally accepted psychiatric and mental health practices and the professional and technical standards adopted by the administrator.

Mental Health Care

Medically Necessary care provided by an eligible provider for the treatment of a mental health or behavioral illness or condition that the administrator has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern, or
- Is associated with a painful symptom, or
- Substantially or materially impairs a person's ability to function in one or more major life activities, and
- Is recognized by the American Psychiatric Association as a mental health or behavioral illness or condition.

Network Benefit

The level of benefits that the Plan will pay when Covered Services are provided by a contracted network provider.

Out-of-Network Benefit

The level of benefits that the Plan will pay when Covered Services are provided by a non-contracted provider.

Substance Abuse Care

Medically Necessary care provided by an eligible provider for the treatment of a substance abuse or chemical dependency illness or condition that the administrator has determined:

- Is a clinically significant behavioral or psychological syndrome or pattern, or
- Is associated with a painful symptom, or
- Substantially or materially impairs a person's ability to function in one or more major life activities, and
- Is recognized by the American Psychiatric Association as a substance abuse or chemical dependency illness or condition.

III. TRADITIONAL DENTAL BENEFIT PLAN

The Traditional Dental Plan becomes effective April 1, 2005, and reimburses covered expenses in four different categories: preventive, basic, major and orthodontia. For basic or major treatment, you must meet an annual per-person deductible for covered dental expenses before the plan pays benefits, as described below. For preventive and orthodontia treatment, the plan pays a percentage of benefits with no deductible. Preventive care benefits are paid at 100%.

DEDUCTIBLE

The annual deductible is the amount of covered expenses you must pay before the program pays any benefits. You pay an annual deductible only for dental treatment that is considered basic or major, as described in the following sections.

Your annual deductible is $50 per person, or a maximum of $150 for a family. The family deductible is combined for all family participants; each individual's covered expenses apply toward the $150 total amount. You may use any combination of basic and major covered expenses to meet the individual or family deductible. When you have met the deductible, you and covered family participants pay no further deductibles for the rest of the calendar year.

CALENDAR YEAR MAXIMUM

The maximum benefit you can receive in a calendar year for any combination of preventive, basic and major treatment is $1,500.

Covered dental expenses are the usual and customary charges for eligible services. These services must be performed or prescribed by a dentist and necessary in terms of generally accepted dental standards.

DEFINITION OF "USUAL AND CUSTOMARY"

For many services, the Traditional Dental Plan pays a percentage of the "usual and customary" charge. This is the prevailing rate charged for a procedure, service or supply, taking into account the geographic area in which the services are provided. Some dental offices may charge more than the usual and customary amount for services. Whatever the cost, however, you are responsible for paying amounts above and beyond the percentage of the usual and customary charge reimbursed by the plan.

PLAN FEATURE	TRADITIONAL DENTAL PLAN*
Deductible	$0 for preventive and orthodontia services $50 per person for basic and major services** $150 per family for basic and major services
Annual Maximum	$1,500 per person – combined for preventive, basic and major treatment
Lifetime Maximum	$5,000 per person for periodontic treatment $1,550 per person for orthodontia

SERVICES	
Preventive • Exams and routine cleanings (or cleanings necessitated by a dental condition)	Plan pays 100%* (no deductible)
Basic • Fillings, extractions and oral surgery • Single crowns	Plan pays 80% after deductible
Major • Bridgework and dentures	Plan pays 50% after deductible
Orthodontia • Braces	Plan pays 50%* (no deductible), not to exceed $1,550

* The Traditional Dental Plan reimburses covered services up to the "usual and customary" charge, which is the going rate charged for a particular service in a particular geographic area. Participants are responsible for paying any amounts over the usual and customary charge.

** The $50 deductible is combined for basic and major services, which means you need to meet this deductible only once in a calendar year before the plan pays benefits.

A. **Preventive Treatment**

You pay nothing for covered preventive care - these services are covered at 100% with no deductible. This includes the usual and customary charges for:

- Clinical oral examinations (maximum of two per calendar year)*
- Dental cleaning (prophylaxis) (maximum of two per calendar year; up to two additional cleanings per year if necessitated by a dental condition)*
- Topical application of fluoride (maximum of two treatments per calendar year)*
- Emergency palliative treatment for dental pain
- Sealants for children up to age 17 (maximum of one treatment per posterior tooth per 36-month period; limited to the occlusal surfaces of permanent molars that are free of decay and restoration)
- Space maintainers to replace prematurely lost teeth for children up to age 19
- Supplementary bitewing X-rays (maximum of two charges per calendar year)
- Cosmetic bonding of up to 16 teeth per person per lifetime.

* Benefits for these services are subject to Delta Dental approval. You may have these services performed more often than the plan allows if your physician or dentist provides adequate evidence of the necessity for additional services with your claim.

B. **Basic Treatment**

After participants meet the annual deductible, they pay 20% and the plan pays 80% of usual and customary charges for:

- Oral surgery
- Periodontic treatment (up to $5,000 life-time maximum)
- Simple extractions of teeth
- Basic restorations (fillings) of carious or broken teeth using silver or resin-based composite filling materials (use of resin-based composite is restricted to specific front teeth only)
- Major restorations of carious or broken teeth using inlays, onlays, gold fillings or crowns, when the teeth cannot be restored by filling materials used in basic restorations
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures; relining or rebasing dentures more than six months after the installation or replacement of the denture, with a maximum of one charge in any 36-month period
- General anesthetics administered with covered oral or dental surgery when medically necessary
- Use of anti-inflamatory drugs for oral surgery
- Injection of antibiotic drugs by the attending dentist
- Endodontics (root canal therapy).

C. **Major Treatment**

After participants meet annual deductible, they pay 50% and the plan pays 50% of usual and customary charges for the following covered services:

- Installing fixed bridgework (including inlays and crowns as abutments)
- Installing partial or full removable dentures (including precision attachments and follow-up adjustments during the six months following installation).

D. **Orthodontia Treatment**

Participants do not have to meet a deductible before the plan provides benefits for orthodontia expenses. Participants pay 50% and the plan pays 50% of usual and customary charges for:

- Comprehensive full-banded orthodontic treatment
- Appliances for tooth guidance (maximum of one appliance per person)
- Appliance to control harmful habits (maximum of one appliance per person)
- Orthodontic retainers (maximum of one appliance per person)

Orthodontic treatment may involve appliances, surgery, functional and myofunctional therapy, and other related treatments to correct the dental irregularities that may result from abnormal growth and development of teeth, gums or jaws or accidental injury.

The plan pays for orthodontic expenses in installments. The first payment is made when the orthodontic appliance is installed. Additional payments are made monthly. Before making the first payment, Delta Dental allots 25% of the charge for the entire course of treatment to the appliance. The rest of such a charge is prorated over the estimated length of treatment.

The maximum benefit in a lifetime for orthodontic treatment is $1,550 for each covered person.

E. **Dental Expenses Not Covered**

The Traditional Dental Plan does not cover:

- Procedures, services or supplies solely for cosmetic reasons, including charges for the personalization or characterization of a denture
- Replacement of a lost or stolen dental appliance
- Replacement of a bridge or denture within five years following the date of the original installation, unless the replacement is necessary due to the placement of an original full denture or the extraction of natural teth; or the bridge or denture has been damaged beyond repair as the result of an accidental injury while the individual is covered under the plan
- Replacement of a bridge or denture that is, or can be made, usable according to common dental standards of functional acceptability
- Procedures, appliances or restorations, other than full dentures, if the primary purpose is to alter dimension, stabilize periodontally involved teeth or restore occlusion
- Porcelain or acrylic veneers or similar properties of crowns and pontics placed on, or replacing, the upper and lower first, second and third molars
- Charges made other than by a dentist, or another physician, acting within the scope of his or her license, except for charges for procedures performed by a licensed dental hygienist under the supervision and direction of a legally qualified dentist or physician
- Services or dental work provided on or after the date your coverage terminates
- Failing to keep a scheduled visit with a dentist, or charges for not completing claim forms
- Replacement or repair of an orthodontic appliance
- Replacement of a lost, misplaced or stolen prosthetic device or appliance
- Counseling or supplies for oral hygiene or dietary instruction
- Plaque control programs
- Sargenti-type root canal therapy

- Implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants
- Periodontal splinting
- Procedures, services or supplies that do not meet accepted standards of dental practice, including charges for procedures, services or supplies that are experimental
- Services or supplies received as a result of dental disease, defect or injury due to war or any act of war (declared or undeclared)
- Services or supplies received as a result of past or present service in the armed forces of a government or under any law of a government, except where the government plan establishes payments or benefits for its civilian employees or their dependents, in which case the program's coordination of benefits rules apply
- Services from a medical department, clinic or similar facility provided or maintained by a family participant's employer, unless the individual is legally obligated to pay the charge
- Charges related to an injury resulting from employment for wage or profit
- Charges related to a sickness for which the employee or dependent is entitled to benefits from Workers' Compensation or a similar law
- Charges in a hospital or dental facility owned or operated by the United States government
- Charges if payment under this plan is prohibited by any law of the jurisdiction in which the employee or dependent resides at the time expenses are incurred.
- Charges that the employee or dependent is not legally required to pay, or charges that would not have been made if no dental coverage had existed
- Charges in excess of usual and customary limits
- Charges for unnecessary care or treatment
- Charges for which the employee or dependent is reimbursed by a public program
- Services rendered by a participant of the employee's immediate family
- Services related to temporomandibular joint disorder (TMJ)

F. Pre-Determination of Benefits

Taking the guesswork out of your dental coverage may alleviate some concerns about the cost of treatment. CNH provides a "Predetermination of Benefits" procedure.

The Predetermination of Benefits process is typically used when the anticipated treatment is expected to be expensive (generally over $125). Predetermination is recommended for services that involve crowns, fixed bridgework and other significant treatment. In these situations, ask your dentist to describe the recommended treatment, estimate the charges and send the information to Delta Dental for review. The participant and dentist will be notified of the benefits payable under the program based on current available benefits, or if additional information is required before a determination can be made.

The dentist should send a revised plan to Delta Dental if there is a major change in the treatment plan. When the treatment is completed, the dentist simply needs to put the service date on the reply sent to his or her office, sign and date it, and then return the document to Delta Dental.

Predetermination of Benefits is intended to enable the participant and dentist to reasonably and realistically plan treatment. The process provides a reasonable estimate of benefits that

would be payable under the program based on facts and circumstances at the time the estimate is requested. The process does not guarantee payment.

The pre-determination method should not be used for:

1) Emergency treatment; or

2) Routine oral exams; or

3) X-rays, cleaning and scaling, and fluoride treatments; or

4) Dental services which cost less than $125.

G. Dental Expense Coverage After Benefits End

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person end. This will apply even if a pre-determination of benefits for dental services has been approved. However, benefits for Covered Dental Expenses incurred for a Covered Person for the following services will be paid after Dental Expense Benefits end:

1) For a prosthetic device if:

   (a) The dentist prepared the abutment teeth and made impressions while the Dental Expense Benefits for the covered person were in effect; and,

   (b) The device is installed within sixty days after the date the Dental Expense Benefits end; or

2) For a crown if:

   (a) The Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; and,

   (b) The crown is installed within sixty days after the date the Dental Expense Benefits end; or

3) For root canal therapy if:

   (a) The dentist opened the tooth while the Dental Expense Benefits for the Covered Person were in effect; and

   (b) The treatment is finished within sixty days after the date the Dental Expense Benefits end.

IV. VISION PLAN

The vision coverage program is administered through a vision care third party administrator. The third party administrator has developed a nationwide network of vision care professionals,. You can choose to use this network by going to a network doctor, or you can be reimbursed in part for getting your routine eye care from a doctor who is not a participant of the administrator's network.

If you use the network, covered services are prepaid with no deductible. If you use the services of a doctor who is not a participant in the network, the program reimburses you for covered expenses according to a schedule of benefits.

A. What the Program Covers

Through the network, participant doctors agree to perform services at agreed-upon fees. If you use any other doctor, the program pays a portion of the costs based on a schedule of fees for certain covered services.

1) Using a network provider

If treatment is by a network provider, the program pays:

(a) 100% for an annual routine eye examination.

(b) 100% each year for lenses. This includes single vision, bifocal and trifocal lenses as well as tinted and photochromic lenses. If a doctor prescribes other more complex and expensive lenses that are medically necessary, they are covered in full.

(c) 100% each year for most frames. The program offers a wide choice of frames. You pay the difference between the wholesale price for the standard frames and the wholesale price of the optional frames.

(d) 100% each year for contact lenses "*medically necessary*" for any of these conditions:
- following cataract surgery,
- to correct extreme vision problems that cannot be corrected by eyeglasses,
- certain conditions of anisometropia, and
- keratoconus.

(e) $150 total for the eye exam and contact lenses that are not medically necessary (i.e. medically necessary means your vision cannot be corrected with eyeglasses).

If the employee or dependent gets contacts, any eyeglasses purchased for that person will not be covered that calendar year.

2) Using a nonparticipating provider

Instead of going to a network provider, participants can be treated by the licensed optometrist, ophthalmologist or eye specialist of their choice. When they go to the doctor or purchase eyeglasses or contact lenses, they will pay the full cost, then apply for partial reimbursement from the program. Each calendar year, the program pays for each covered family participant:

(a) Up to $35 for an annual routine eye examination.
(b) Up to:
- $35 a pair for single vision lenses.
- $52.50 a pair for bifocal lenses.
- $70.00 a pair for trifocal lenses.
- $87.40 a pair for lenticular lenses.
- $5 for tinting.
(c) Up to $35 a pair for frames.
(d) Up to $200 a pair for medically necessary contact lenses. VSP must approve the medically necessary lenses before participants can receive reimbursement for them. Contacts are considered medically necessary:
- following cataract surgery,
- to correct extreme vision problems that cannot be corrected by eyeglasses,
- certain conditions of anisometropia , and
- keratoconus.

If vision can be corrected with eyeglasses but the participant decides to purchase contact lenses, the program will pay $150 toward the cost of the eye exam and elective contact lenses. This benefit is the same regardless of whether the participant goes to a network participating provider or not.

B. Optional Services

The vision program is designed to provide necessary eye care and corrective eyeglasses.

If a participant wants to purchase certain optional services, they can buy these extras for additional cost. The network provider can tell them whether something is covered by the program or is considered an option.

Examples of options for which participants will pay extra money include:

- Blended lenses,
- Oversize lenses,
- Progressive multifocal lenses, e.g., progressive bifocals,
- Coated or laminated lenses,
- Frames costing more than the program allowance,
- Certain costs for low vision care,
- Cosmetic lenses (lenses for eyeglasses that serve no corrective vision purpose),
- Ultraviolet-protected lenses, and
- Optional cosmetic processes.

C. **Expenses Not Covered**

The vision program does not pay any benefits for:

- Orthoptics or vision training and any associated supplemental testing,
- Plano lenses (noncorrecting),
- Two pairs of glasses instead of bifocals,
- Medical or surgical treatment for the eyes. (This may be covered by the medical coverage, if enrolled in that program,)
- Any eye examination or corrective eyewear required by an employer as a condition of employment,
- Lost, stolen, or broken eyeglasses or contact lenses,
- More than one pair of eyeglasses or contact lenses during the calendar year.

One other important note: Participants must notify the network provider's office of their network plan participation. Otherwise, they may be billed as a private patient. In this case, the participant may apply to the provider for reimbursement as non-network expense and the participant will pay any charges above what the program pays.

V. FLEXIBLE SPENDING ACCOUNTS - Active Employees Only

Effective January 1, 2006, active employees will be eligible to participate in two flexible spending accounts.

- Healthcare FSA, with employee contributions up to $4,800 per year. Contributions are taken from employee pay on a pretax basis and may be used to pay for qualified medical, dental and/or vision expenses. Restrictions apply on use of all monies in a plan year, continuance or deductions.
- Dependent Day Care FSA, allows employees to contribute up to $4,980 per year (subject to applicable IRS limits).

A. Healthcare Flexible Spending Account

Eligible active employees may use the Healthcare FSA to pay expenses for themselves and their eligible dependents, that are not reimbursed by any other health care plan or coverage. The plan follows IRS Publication 502 (Medical and Dental Expenses), and generally includes the following eligible expenses:

- Annual deductibles or network service copayments, prescription drug copayments, and the participant's share of covered expenses.
- Amounts the participant pays in excess of a health care plan's limits, such as reasonable and customary fee reductions, additional mental health treatments, etc.
- Items or services not covered by a health care plan that are considered tax-deductible medical expenses by the IRS
- Health care items or services for which the participant does not have coverage.
- Fees for services performed by licensed physicians, dentists, chiropractors, podiatrists, optometrists, opticians, psychologists, osteopaths, therapists, nurses, and technicians.
- The cost of prescription drugs, insulin, and certain eligibile over-the-counter items such as allergy medicines, pain relievers, nicotine gum or patches, etc. (as permitted by the IRS and detailed in the SPD).
- Expenses resulting from treatment in hospitals, clinics and other licensed medical facilities.
- Prosthetic devices, including artificial limbs, artificial teeth, crutches, dentures, eyeglasses, and hearing aids.
- Expenses resulting from illness and procedures including, but not limited to the following examples:
  - Acupuncture
  - Braces
  - Braille - books and magazines
  - Contact lenses
  - Convalescent care facility
  - Diagnostic fees
  - Eye care expenses
  - Guide dog and upkeep
  - In-vitro fertilization
  - Laboratory fees
  - Lamaze classes
  - Orthodontia
  - Oxygen
  - Psychiatric care
  - Therapeutic care for drug and alcohol addiction

- Wheelchairs
- X-rays

B. Ineligible Healthcare FSA Expenses

The following is a partial list of healthcare expenses (such as professional services and medical treatments, equipment and supplies, and miscellaneous expenses) that are not eligible for reimbursement through the Healthcare FSA.

- Professional Services and Medical Treatments:
  - Athletic or health club memberships
  - Babysitting fees to enable you to receive medical treatment
  - Cosmetic surgery that is not medically necessary
  - Deductions from employee wages to pay for any state or employer sponsored healthcare coverage
  - Domestic help, except for nursing duties
  - Marriage counseling fees
  - Medical tratments, services or medicines that are illegal in the location where you receive them
- Equipment and Supplies
  - Air conditioner, even if prescribed by a physician.
  - Bottled water bought to avoid drinking fluoridated city water
  - Cosmetics
  - Piercings
  - Special food or beverage subsubstitutes
  - Miscellaneous articles, such as toothpaste and other toiletries.
- Over-the-counter items
  - Aromatherapy
  - Baby oil, wipes, bottles, etc.
  - Cosmetics
  - Dental floss
  - Deodorants
  - Facial Care
  - Feminine Care
  - Hair Regrowth
  - Special diet foods
  - Oral care
  - Shampoo and conditioners
  - Skin care
  - Sun tanning products
- Miscellaneous
  - Expenses incurred before the employee began participating in the Healthcare FSA
  - Expenses incurred after the employee ceased participation
  - Antiseptic diaper services
  - Funeral, cremation, burial, cemetery plot, monument, or mousoleum expenses
  - Health programs offered by resort hotels, health clubs, and gyms
  - Maternity clothes
  - Expenses of a former spouse
  - Premiums for life insurance policies, disability income policies.
  - Premiums for any health care coverage
  - Premiums for Long Term Care Insurance

- Transportation costs of a disabled person to and from work
- Tuition and travel expenses to send a problem child to a special school for a beneficial change in environment
- Veterinary fees.

If the FSA reimburses a participant for an ineligible espense, it is the participant's responsibility to repay the money.

C. Dependent Day Care Flexible Spending Account

Eligible active employees may use the Dependent Day Care FSA to pay certain employment-related dependent day care expenses. These are expenses the employee pays to a care provider or center for the care of their dependent while they work. The account also reimburses expenses if they work and their spouse is a full-time student.

The IRS limits eligible dependents to the employee's dependents under age 13 who can be claimed as an exemption on their federal income tax form; and their dependents of any age (including parents) who are physically or mentally incapable of self-care and depend on the employee for at least 50% of their support; an incapacitated dependent who is age 13 or over must regularly live in the employee's household at least eight hours a day.

The IRS has certain restrictions on the use of the Dependent Day Care FSA. The only expenses the employee may claim are those that would otherwise qualify for the dependent care tax credit on their federal income tax return. Further, reimbursements received through the Dependent Day Care FSA may not also be claimed as a tax credit on the employee's federal income tax return.

The Plan follows IRS Publicatin 503 (Child and Dependent Care Credit) to determine eligible expenses. Below is a partial list of eligible Dependent Day Care expenses:

- Licensed care centers, nursery school, and pre-school, if the care center or school complies with the state and federal regulations
- Babysitter costs, or wages or salary for a care provider inside or outside the employee's home; if the care provider is a relative, he or she must be age 19 or older, and cannot be the employee's dependent.
- Nonresidential dependent nursing or custodial care in the employee's home for an elderly or disabled dependent who is unabel to care for himself or herself
- Social Security and other taxes the employee pays on behalf of a care provider

Note: The employee must include the Social Security number or tax ID number of the person or center providing the care in order to qualify for reimbursement.

D. Dependent Day Care Ineligible Expenses

The following is a partial list of dependent daycare expenses that are not eligible for reimbursement through the Dependent Day Care FSA.

- Expenses the employee incurred before they began participating in the Dependent Day Care FSA
- Payments provided by someone the employee claims as a dependent on their federal income tax return.
- Payments to the employee's child (or stepchild) who is under age 19 at the end of the taxable year

- Schooling costs for children in kindergarten or older (if the cost of care can be separated from the cost of schooling, only the cost of care is an eligible expense)
- Amounts the employee claims as a tax credit on their federal income tax return for the calendar year
- Overnight camp expenses
- Transportation expenses for travel to and from the dependent day care provider
- Finder's fees for placement of an au pair or nanny
- Expenses incurred for a dependent during any period in which the employee cannot claim that individual as a dependent for income tax purposes.
- Expenses incurred after participation ceases.

If the FSA reimburses a participant for an ineligible espense, it is the participant's responsibility to repay the money.

E. Claims and Account Forfeitures

Claims for a calendar year must be received by the claims administrator by March 31 of the following calendar year to be eligible for reimbursement. Claims are processed weekly, and a claim must total at least $10 to be processed (except for the final reimbursement from the account for the year).

FSA accounts are separate and money cannot be transferred between them for any reason.

The IRS requires that participants forfeit any balance in their FSA account(s) not used for expenses incurred during the calendar year. **Participants cannot carry over a balance in an FSA from one calendar year to the next.** If a partidicpant does not have enough eligible expenses to claim all of their deposits to their FSA, the law requires them to forfeit the money remaining in their account.

VI. GENERAL

A. Eligibility

1) An employee shall be eligible for coverage on his own account on the day immediately following the completion of the length of continuous service noted below, provided that the employee is actively at work on that day (unless otherwise required by federal regulation).

Waiting Periods for Employees Hired or Rehired on or After May 14, 1998:

(a)	Life, AD&D, and CNH Health Care Plans	3 months
(b)	Weekly A&S Benefits	3 months
(c)	Dental Plan	18 months
(d)	Vision Plan	18 months
(e)	Long Term Disability	24 months

2) Dependent's coverage shall be effective:

(a) On the effective date of the Employee's coverage provided the dependent is not confined in a hospital or other institution for care or treatment; or is not confined at home under the care of a physician or surgeon because of a disabling physical or mental sickness or injury. If so confined or disabled, coverage for that dependent shall not be effective until he or she has been discharged from the hospital or other institution, or is no longer confined at home under the care of a physician.

(b) Upon enrollment for Dependent Coverage by the employee, provided enrollment is made within thirty days of the date the employee acquires the dependent; in which CNH coverage will become effective on the date the person becomes the dependent of the employee.

B. **Annual Enrollment**

Each year participants will be provided the opportunity to change their benefit election for the upcoming calendar year. After the beginning of a calendar year a participant may not change their coverage election unless they encounter a Change in Family Status as permitted under Section 125 of the Internal Revenue Code.

1) Change of Family Status
In the event that an employee encounters a qualifying change in family status, they will be given the opportunity to change their annual benefit election provided they do so within 30 days of the qualifying event. Otherwise, enrollment election changes can only be made during the annual enrollment period. Complete details of qualifying family status changes will be provided in the Summary Plan Description.

C. Cessation of Coverage

1) Coverage shall automatically cease on the date employment terminates. For purposes of coverage, termination of employment means cessation of active work as an employee, except that in circumstances specified below and as provided by Paragraphs D, E and F which follow:

(a) Life Insurance benefits shall continue to be payable for thirty-one days thereafter.

(b) On the date of cancellation of healthcare coverage, the employee will be offered COBRA continuation option.

2) The following Conversion Privileges shall be available upon cancellation of the group coverage:

(a) Life insurance up to the amount provided under the Group Plan may be continued under an individual policy, without evidence of insurability, provided application is made to the Insurance Company within thirty-one days of the cancellation date. The amount of such individual policy may, at the option of the Employee, be increased by an amount equal to the total amount of Survivor Income Benefits Insurance payments (Transition and Bridge) that would have been made if the employee had died on the date of termination of employment.

D. **Provisions Applicable to Employees on Lay-Off**

1) The following Group Coverage shall be continued in effect as stated below for employees who cease active work due to a lay-off:

(a) Coverage for Employees Only

1. Group Life Insurance
2. Accidental Death & Dismemberment
3. Survivor Income Benefits (Transition & Bridge)

(b) Coverage for Employees & Dependents

1. Medical Plan
2. Prescription Drug Plan
3. Dental Plan
4. Vision Plan

2) An employee placed on lay-off will have certain group coverages continued according to the following schedule:

(a) Coverage Based on SUB Eligibility

All coverages listed above (1) shall be continued for one full calendar month of lay-off, not to exceed twelve (12) months, for each full four weeks of benefits to which the employee's SUB eligibility would entitle him on the basis of his seniority and SUB eligibility as of the last day of work prior to lay-off.

(b) Coverage Based on Seniority for employees hired prior to May 14, 1998.

Years of Seniority	Weekly Benefit	Maximum Duration
1 - 10	$200	26 Weeks
10+	$200	52 Weeks

(c) Employees hired on or after May 14, 1998

Years of Seniority	Weekly Benefit	Maximum Duration
1 - 5	$100	13 Weeks
5+	$125	26 Weeks

The continuation will be based upon the greater of the above calculations. The employee shall have the conversion privileges available upon expiration of the period of continued group coverages listed above.

An employee with ten or more years of seniority at the time of lay-off due to a full or partial plant closing will receive an additional twelve months of Group Life Insurance & Medical coverage (including prescription drugs), excluding Dental, Vision and Hearing Benefits.

3) Conversion Privileges

The Conversion Privileges described in Paragraph B above, shall be available to employees upon expiration of the period of continued Group Coverage listed above.

E. **Provisions Applicable to Employees on Disability Leave of Absence**

A disabled employee will be eligible to continue coverage and applicable rates in effect as an employee for Life, Medical, Dental, Prescription Drug, and Vision for the period during which he receives Weekly Accident and Sickness benefits and Long-Term Disability benefits.

1) Conversion Privilege

The Conversion Privileges described in Paragraph B above shall be available to employees upon expiration of the period of continued Group Coverage listed above.

F. **Maternity Leave of Absence**

Employees placed on Leave of Absence for maternity will be permitted to continue Life, Medical, Dental, Prescription Drug, and Vision coverages at normal active employee rates, if required for up to twelve (12) months following the date the Leave of Absence commenced. The coverage shall include eligible dependents.

G. **Contested Worker's Compensation Claim**

In the event of a contested claim for Worker's Compensation Benefits, the following procedure will be followed:

1) With regard to medical services, the Company physicians, at their discretion, may either treat the employee, refer him to an outside physician, or permit him to go to a physician of his choice (subject to applicable State law).

2) The employee shall receive an amount of money equal to his current Weekly A&S rate, but this benefit will not be considered either Weekly A&S or Worker's Compensation until such time as the dispute is finally resolved.

3) The employee will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in favor of the employee which duplicates a payment previously made by the Company, will be returned to the Company by the employee, or deducted from any final settlement the Company may be required to make.

The above action taken while the dispute is pending will in no way impair the rights of the employee or the Company nor be used to prejudice the position of either.

H. Leave of Absence

1) Union Business

Medical, Dental, Prescription Drug, and Vision Coverage will be continued at the applicable active employee rates during an approved leave of absence requested by the Local Union to permit an employee to work on a full-time basis for the Local Union for a period not longer than the balance of the month in which the leave commenced plus the following full calendar month. Thereafter, the employee shall be entitled to continue such coverage by paying the full cost thereof.

2) Personal

The group coverage (life insurance, accidental death & dismemberment, survivor income benefit insurance, medical, dental, prescription drug, and vision) shall be continued in force at the applicable active employee rates for the month following the month in which the Leave commences.

I. **Special Age 65 Benefit (Medicare Payment)**

1) The Special Age 65 Benefit (Medicare payment) shall be payable to active employees age 65 or older and on behalf of the employee's spouse if covered by Medicare Part B. The Medicare payment shall be payable to disabled employees who are eligible for Medicare (and provide the Company with proof of enrollment) during the period they are receiving Long Term Disability Benefits and monthly installment Life Insurance Benefits.

The Medicare Payment shall be increased on the date(s) indicated:

May 2004 – December 31, 2006	$65.50 or actual amount if less
January 1, 2007	$100 or actual amount of Part B & Part D premium if less

2) In addition, the Medicare Payment is payable on behalf of:

a) Employees who retired on a company-provided pension on or after December 1, 2004;

b) The eligible spouse of retired employees who retired on or after December 1, 2004; or

c) Surviving spouses of employees who retired on or after December 1, 2004, receiving a spouse's pension or who will receive a spouse's pension upon exhausting Transition and Bridge benefit payments.

If the company provided coverage is primary for active employees and their eligible dependents or disabled employees and their eligible dependents, the company will not reimburse the employee (active or disabled) or eligible dependents the Medicare premium.

The retired employee, spouse, or surviving spouse must have retired on or after 12/1/04 and be enrolled for Medicare Part B (and Medicare Part D beginning January 1, 2007). The benefit is not payable, however, if a Medicare repayment is being paid on behalf of the retired employee or spouse from another source.

This benefit is not applicable to former employees or spouses of former employees receiving a pension due to eligibility under the Pension Plan provisions for deferred, pension benefits.

J. **Provisions Applicable to Employees Retired on Company Pension and Surviving Spouses Receiving Company Pension**

1) Employees who retire under the CNH U.S. Pension and are at least age 55 with at least 10 years of service (on their retirement date) on or after December 1, 2004, or their surviving spouses, shall be eligible for the Group benefits as described in the following paragraphs. All other coverages cease coincident with the date of employment termination due to retirement. (The provisions of this section shall not apply to individuals eligible for or receiving retirement benefits under the deferred vested provisions of the Pension Plan.)

(a) The following benefits will apply to employees who retire on/or after the dates noted and who have ten (10) or more years of service, and are 55 or over at the retirement date.

Group Life Insurance - Retired Employees Only (Including Disability Retirements)

Employees who retired on or after March 1, 2005:

1. For employees who were hired prior to May 14, 1998, , the benefit will be the same as their life insurance level as an active employee for the first year of retirement. At the first anniversary of the retirement, the benefit level will be reduced by 50%; at third anniversary of retirement, the benefit will be eliminated.

2. Employees hired after May 14, 1998, have life insurance after they retire at the same level they had as an active employee, until their first year of retirement. At the first anniversary of retirement, the benefit level will be reduced by 50%; at the third anniversary the benefit will be eliminated.

Employees who retired on or after December 1, 2004 and before March 1, 2005:

1. Employees retiring on Company provided pensions due to permanent and total disability, in which the disability commenced after July 1, 1994, shall have the amount of their Group Life Insurance continued in an unreduced amount until attainment of Age 65. At Age 65, the Life Insurance shall be reduced by 25%; then reduced again by 25% of the original active amount upon attainment of age 66. The resulting benefit will be 50% of the original active amount.
2. For employees hired prior to May 14, 1998, the benefit will be the same as their life insurance level as an active employee until age 65. At Age 65 the benefit level will be reduced by 25%; at age 66, the benefit will be reduced again by 25% of the original amount.
3. Employees hired after May 14, 1998 have $7,500 of life insurance after they retire.

Group Health Care

1. The following benefits will apply to employees who retire on/or after the dates noted who are at least age 55 and have ten (10) years of service at the retirement date, or surviving spouse of an eligible retiree.

   Medical* Vision
   Dental

   *Eligibility for specific coverage based on each plan's eligibility requirements.

2. Employees hired after May 14, 1998, are not eligible for health care coverage.

(b) Employees who retired with less than ten years of credited service or who are under age 55 are not eligible for coverage.

2) Enrollment

Eligible Retired Employees and Surviving Spouses are required to complete an enrollment form in accordance with Group Plan provisions for the continued coverages as described above, and provide evidence of enrollment in Part B and Part D of Medicare, as required. In the event of the inability of a Retired Employee or Surviving Spouse receiving a Spouse's Pension to enroll in Medicare Part B and Part D because of an enrollment restriction, the requirement of enrollment will be waived until their first opportunity to become enrolled.

3) Contribution for Coverage

(a) Group Life Insurance as stated above shall be fully paid by the Company.

(b) 1. Contributions are required for the Medical Plans.

2. Dependents Age 65 and Over – Not qualified for Medicare

With respect to dependents who are Age 65 and over and who do not qualify for Medicare, for reasons other than non-payment of premium, the Company will either cover the dependent under its HMSD program without a reduction for benefits otherwise provided by Medicare, or provide Medicare reimbursement. The company will notify the Union of its decision in each case.

K. **Deferred, Vested Retirees & Surviving Spouses of Deferred, Vested Retirees**

The provisions of this agreement are not applicable to individuals eligible for or receiving a pension benefit under the provision for Deferred, Vested, Retirement of the Pension Plan, or Surviving Spouses receiving a Spouse's Pension resulting from a Deferred, Vested Retirement or any retiree who has retired from the Company prior to December 1, 2004.

L. **Subrogation**

In the event of any payment of medical/hospital, dental or vision benefits under this Plan for which an employee, retiree, surviving spouse or a dependent may have a claim or cause of action against any person or organization (except a claim or cause of action against an employer and except against insurers of policies of insurance issued to, and in the name of the employee, retiree, surviving spouse, or dependent) CNH or the Administrator shall be subrogated to all right of recovery of the employee, retiree, surviving spouse or dependent with respect to any expenses included in any judgment of settlement only to the extent that said judgment or settlement is expressly identified as a payment for medical/hospital, dental or vision services paid for under this Plan. If the employee, retiree, surviving spouse or dependent incurs attorney's fees in connection with the successful prosecution or settlement of any claim or cause of action which includes such benefits, the employer or Administrator, as the case may be, shall reduce its right of subrogation by a pro rata share of such attorney's fees based on the ratio of the amount of any such medical/hospital, dental or vision benefits paid under this Plan to the total amount recovered by settlement of judgment. The employee, retiree, surviving spouse or dependent shall, at the request of the Company or Administrator, execute and deliver such instruments and papers as may be required and to take such other reasonable steps necessary to secure the subrogation rights.

In cases where subrogation is involved, CNH will proportionally reduce its subrogation interest under the claims of its employees and their dependents when the actual amount recovered reflects less than the proper value of the case* and a reasonable basis exists for accepting such lesser amount in settlement.

To illustrate, assume a liability case has a value of $100,000, but a defendant has only $50,000 coverage and no other available assets, and that a settlement between the plaintiff and the defendant is reached for $50,000. Assume also that the monies expended by CNH for medical

and hospital bills for the plaintiff employee or dependent totaled $10,000. If advised of these facts, and having ascertained their accuracy, CNH would proportionalize its subrogation interest and treat its original $10,000 amount expended as if it were only $5,000. Thus, to the same extent the employee or dependent is deprived of proper compensation for the injury (50% in this example), CNH also proportionalizes its subrogation interest (50%).

Assuming such a settlement, the recovery by CNH would not be of $5,000, but $3,335.

*A proper value of a case is estimated by multiplying the financial loss (medical bills, lost time and property) by five.

M. **Compliance with Federal Law**

To comply with the Federal law, Consolidated Omnibus Budget Reconciliation Act (COBRA), the following applies:

The law provides employees, their spouses and dependent children, the option of continuing group coverage, for specified periods, after the termination of their coverage.

The period of continuation depends on the reasons coverage terminates, as illustrated below:

Termination of Employment	Coverage Continuation
The continuation will be provided to employee and, if applicable, to employee's eligible dependents.	18 Months

(Up to 29 months of extended coverage if determined to be disabled under Social Security, or become disabled within the first 60 days of COBRA coverage. This also applies to all qualified family participants.)

Dependent Born to (or adopted by) a COBRA Beneficiary
Such dependent is also considered a qualified beneficiary and eligible for COBRA for the same period of time remaining for the qualified participant.

Death of Employee	36 months
The continuation will be provided to the surviving spouse and, if applicable, dependents of deceased employee.	
Divorce of Employee/Spouse	36 months
The continuation will be provided to the ex-spouse and, if applicable, eligible dependents.	

Dependent Child No Longer Eligible — 36 months

The continuation will be provided to the eligible dependent child when no longer eligible for coverage.

The Group Coverage may be continued by paying the applicable premium rate. In situations where the Company already provides continued coverage for all or part of the period specified to employee/spouse/dependent, the period of continuation will include the months the Company provides. As an example, in the event of a lay-off, if Group Coverage would be continued for twelve months to employee, the employee would be able to continue Group Coverage for an additional six months by paying applicable premiums.

Benefits may be elected separately as follows:

- Medical/Prescription
- Dental
- Vision

Or, a combination of some or all three.

N. Coordination of Benefits

1) Definitions

(a) "Plan" means a plan which provides benefits or services for or by reason of medical care and which is:

1. a group insurance plan; or
2. a group blanket plan; or
3. a group practice plan; or
4. a group service plan; or
5. a group prepayment plan; or
6. any other plan which covers people as a group; or
7. a government program or coverage required or provided by any law, including any motor vehicle no-fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

(b) "This Plan" means only those parts of This Plan which provide benefits or services for medical care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or

2. Plans which the Employer (or an affiliate) contributes to or sponsors; will not be affected by this Coordination of Benefits provision.

For the purpose of applying this provision, if both spouses are covered as Employees under This Plan, each spouse will be considered as covered under separate Plans.

(c) "Allowable Expense" means any reasonable and customary charge which meets all of the following tests:

1. It is a charge for an item of necessary medical expense; and

2. It is an expense which an Employee or Dependent must pay; and

3. It is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expense does not include expense for services received because of:

1. an occupational sickness; or

2. an occupational injury.

(d) "Claim Determination Period" means a period which starts on any January 1st and ends on the next December 31st. However, a Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

2) Effect on Benefits

If you are covered by more than one group medical plan (and/or Medicare), the benefits you receive from the CNH plan are subject to Coordination of Benefits (COB) rules.

COB rules prevent a duplication or double payment of the provider's charges for services. One plan is considered primary and pays first. The other is considered secondary and pays second.

Under COB rules, your total benefit from your group plans (including Medicare) may be up to, but not more than, the benefits the CNH plan would pay if it were primary. In other words, you may not receive more than the CNH plan would pay if it were primary.

This approach to coordination of benefits does not provide for 100% reimbursement of health care expenses. Instead, it allows two programs together to pay what the CNH plan would otherwise pay if it were the only plan providing benefits. These rules do not apply to any nongroup insurance you purchased yourself.

The sum of all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under this plan.

(a) When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

1. Non-Dependent/Dependent - The Plan which covers that person other than as a dependent determines its benefits before the Plan which covers that person as a dependent.

2. Dependent Child/Parents Not Separated or Divorced -Except as stated in Rule 3 below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents", benefits for that child will be determined in this order:

   a. The Plan of the parent whose date of birth (excluding year of birth) falls earlier in a year, determines its benefits before the Plan of the parent whose date of birth (excluding year of birth) falls later in that year. If both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.

   If either Plan which covers the person has not adopted the above rule, both Plans will determine their benefits by determining the father's benefits before the Plan of the mother.

3. Dependent Child/Separated or Divorced Parents - If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for that child will be determined in this order:

   a. First, the plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity which is obligated to pay or provide the benefits of the Plan of that parent was actual knowledge of those terms, the Plan which covers the child of that parent determines its benefits first. Then follow the above Rules 3.(a), (b) or (c) to determine which Plan pays next. This paragraph does not apply with respect to any Claim Determination period during which any benefits are actually paid or provided before that entity has that actual knowledge.

4. Active/Laid-Off or Retired Employee - The Plan which covers that person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if as a result, the Plans do not agree on the order of benefits, this Rule 4. will not apply.

5. Longer/Shorter Time Covered - If none of the above rules 1, 2, 3 or 4 determines the order of benefits, the Plan which has covered that person for the longer time determines its benefits before the Plan which covered that person for the shorter time.

   a. Any reduction in the benefits under this Plan will be applied proportionately to each benefit that would have been paid in the absence of this Coordination of Benefits provision.

3) Exchange of Information and Payments

(a) We may, without the consent of or notice to any person, give or receive any information about coverage, expenses and benefits which is needed to apply this provision subject to complying with applicable federal regulations.

(b) To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Any person who claims benefits under this Plan must give to us the information we need to apply this provision.

(c) We have the right to recover any overpayment we make under this Plan from any party who benefited from the overpayment.

(d) If payments which should have been made under this Plan were made under any other Plans, we may pay the party which made the other payments any amounts which we deem proper under this provision. Amounts so paid will be deemed benefits under this Plan. We will be fully discharged from liability under this Plan to the extent of such payments.

O. **Pre-Certification - Active & Retirees**

1) This program is designed to involve the employee and the physician in controlling health care costs under the National PPO Medical Plan and the Non-Network Plan. (A separate precertification process applies to Substance Abuse and Mental Health conditions. See number 6 at the end of this section for details.)

If an employee or one of his dependents is being scheduled for non-emergency hospitalization, the physician has to participate in the Pre-Certification Review.

--- Have the physician call the toll-free Certification telephone number and pre-certify the admission.

2) If admission is not confirmed as being necessary, the administrator's physician will review the case with the employee's physician.

3) In an emergency, if the problem is life-threatening, you should be taken to the hospital, as pre-certification is not necessary. If admitted, you, or the attending physician or hospital must notify the Certification Team within 48 hours.

4) If the employee does not have a non-emergency hospital admission pre-certified through the review program, the employee would pay 100% coinsurance up to a maximum penalty of $1000.

5) To alleviate concerns about the application of an inappropriate copayment, the following will identify situations where the copayment would not be applied:

(a) Emergency confinements where patient's condition precludes informing the hospital that certification is necessary (i.e., unconscious, severe accident, no identification).

6) Substance Abuse and Mental Health Care Precertification (National PPO and Non-Network medical Plans)

In order to be eligible for any benefit coverage for mental health or substance abuse conditions the employee (or a family participant) must call the pre-certification number on their medical ID card prior to any treatment.

The pre-certification administrator will assist the employee (or participant) in assessing the situation and ensuring quality care.

In case of emergency, requiring inpatient treatment, the employee (or family participant) must contact the pre-certification administrtor within 24 hours of hospital admission to assure that treatment will be covered.

If the precertification administrator is not contacted as specified, no benefits are available under this plan. If the pre-certifiction administrator is contacted, but the employee (or participant) elects not to use network benefits and follow the pre-

certification administrator's recommendations, they will be subject to a higher deductible, and benefits will be reduced to 65%.

P. **Summary Plan Descriptions**

The Company agrees to provide each employee with a Summary Plan Description, describing the benefits and provisions of the Group Coverage.

Q. **Severe Delays in Claim Payments**

Whenever payment of a claim covered by the Company's Group Benefit Plan has been unduly delayed through no fault of the employee, the Company or Administrator will take action to relieve the employee from harassment by a creditor or collection agency resulting from such delay.

Upon request from the employee, the Company or Administrator will notify the creditor or collection agency that the employee is covered by the Plan and that payment will be made in accordance with the terms of the Plan when the problem causing the delay has been resolved. A copy of the letter to such creditor or collection agency will be sent to the appropriate credit bureau in the area in which the employee resides.

R. **"Administrator"**

The term "Administrator" as used in this Plan may mean the company, an insurance company, third party claims administrator or other intermediary selected by the Company to administer the program of benefits provided under the Plan.

LETTER OF UNDERSTANDING

Re: National and State Health Insurance Initiatives

This confirms our understanding that if, during the term of the 2005 Collective Bargaining Agreement, any Federal or State health security act is enacted or amended to provide hospital, surgical, medical, prescription drug, dental benefits, vision care, or hearing care for employees, retired employees, surviving spouses and dependents, which duplicate or may be integrated with the benefits of the Group Benefits Plan, then in such event, the benefits under the Group Benefits Plan will be modified so as to integrate or eliminate the duplication of such benefits with the benefits provided by such Federal or State law.

Both parties understand that any savings which the Company may receive as a result of these governmental programs will belong to the Company. The Company shall be under no obligation to provide for any additional benefits other than those agreed to by the parties.

CNH America LLC
Group Insurance Plan
Effective 2005

LETTER OF UNDERSTANDING

Re: Cost of Healthcare Coverage – Active Employees

Contributions for Medical coverage for active employees, employees on layoff, employees on A&S and other similarly situated employees beginning April 1, 2005 will be the same contributions required by the CNH non represented employees for enrollment in the National PPO Plan (based upon enrollment category). Effective January 1, 2006 and January 1, 2007 the contribution levels will be adjusted in the same manner as the non represented employees for the same enrollment category (using a four tier enrollment category). Beginning January 1, 2008 the required contributions will be set at 15% of the total plan cost projected for each plan year based upon UAW plan experience. Plan cost is comprised of projected claim and administrative costs for each specific category of coverage. These contributions will be taken from the first four paychecks per month on a generally equal basis and will be taken on a before tax basis.

Verification of plan cost will be provided as noted by separate letter of understanding.

Contributions for medical plan participation will be deducted from employee pay on a pre tax basis. To remain eligible for coverage, employees must properly authorize such deductins. Once enrolled in the plan, participants cannot change their enrollment election or their coverage tier (except during the annual enrollment period), unless they have a qualifying change in family status.

Letter of Understanding

... Cost of Healthcare Coverage – Retirees, Surviving Spouse and LTD

Contributions for Medical coverage for retirees (who retire on or after December 1, 2004) and surviving spouse and LTD participants' coverage beginning December 1, 2004 will be the same contributions required from the CNH non represented retirees for enrollment in the National PPO plan. Effective April 1, 2005 and through December 31, 2007, the required contributions for single coverage will be equivalent to the rates in place for the non represented retirees who elect single coverage. Retirees who elect family coverage will have required contributions equal to two times the single retiree rate. Beginning in January 2008 the required contributions will be adjusted to reflect a formula whereby the increase in total plan cost from the prior year (2007) projected to 2008 (using UAW participant experience) will be prorated so the retiree contributions will be adjusted to pick up 60% of the added cost in 2008 and each subsequent year.

In the event that there are fewer than 200 retirees covered by the retiree medical plan in years 2008 (as of June 30 of the preceding year) and beyond the contributions will be smoothed to reflect the percentage change experienced by the UAW active medical plan for the applicable timeframe and that percentage of increase will be used as the assumed increase in total retiree plan costs to which the 60/40 cost sharing will then be applied. This does not indicate that the active plan costs will be used to determine retiree contributions but rather the percentage increase of plan costs. Once there are 100 or more retirees enrolled for medical coverage their plan costs will solely be used for determining contributions.

The required contribution will be made via monthly invoice and remittance. Alternatively these participants may elect an ACH option whereby the funds are withdrawn monthly from a participants checking account or deducted from their monthly pension payment.

LETTER OF UNDERSTANDING

RE: Annual Insurance Meeting

During the terms of this Agreement, the Company will schedule annual meetings at plant locations which will be attended by the Local Union Presidents, Bargaining Committee Chairmen, Local Union Insurance Representatives, and representatives of the Plant Human Resources Department and Corporate Benefits Department to review insurance claim administration if disputes are unresolved. At the request of the Company or the Union, a representative of the carrier will be in attendance at the meeting.

In addition, an annual meeting will be held at which one representative from the UAW Ag-Implement Department and one representative from the UAW Social Security Department and one insurance representative from each plant location will meet with the Company Benefits and Human Resources Management or their representatives, and representatives of the insurance carrier to discuss insurance plan administration.

International Union, UAW CNH

LETTER OF UNDERSTANDING

RE: Wellness/Fitness Programs

The Union and the Company agree that helping to keep employees and their dependents healthy is a shared objective.

The Union and the Company agree to work together on specific wellness/fitness program including but not limited to: cancer detection, smoking cessation, weight loss, physical fitness, stress management and nutrition for active and retired employees and their dependents.

By encouraging employee, retiree, and dependent involvement, it is expected that in addition to physical well-being there is a potential for reduction in health care costs.

The specific programs will be designed by a joint CNH/UAW task force and implemented based on local plant employee, dependent, and retiree needs.

International Union, UAW CNH

LETTER OF UNDERSTANDING

RE: Group Benefit Plan

Republic Service Bureau, Inc. (or as appropriate)

The patient, employee, or deceased named on the attached authorization is an employee of CNH. It is understood that the patient, employee, or deceased is not financially responsible for additional expenses detected during your firm's review of the charges associated with the care or treatment provided to the patient, employee or deceased.

If you have any questions, please contact me at (___ ___-___).

Sincerely,

Human Resources Manager

Note: This letter will be signed by the local Human Resources Manager and attached to the authorization form the employee returns to the outside audit firm.

International Union, UAW

CNH

LETTER OF UNDERSTANDING

RE: Claims Procedure and Insurance Meetings

During the 1998 Negotiations, the Company and Union discussed the procedure to be utilized to handle administrative issues and contested claims. The parties agree that the following understanding was reached.

A. Employees should use the informal procedure in each location to obtain answers to insurance matters.

B. If the employee does not get the matter resolved, a form for referring the matter should be submitted by the employee to the Local Insurance representative who will review the matter with the Plant Human Resource Manager or representative. If not resolved then it will be reviewed at the Plan meeting attended by a Corporate Benefits representative and a representative from UAW AG Impl Department referred to in the Letter of Understanding - Annual Insurance Meetings.

C. If the matter is not resolved at that level, the matter will be brought before the National - Corporate Committee at mutually convenient times during the year.

International Union, UAW CNH

LETTER OF UNDERSTANDING

RE: Notice of Retirement

Each Union represented employee who wishes to retire must provide the Company at least 60 days notice of their intent to retire. Failure to provide at least a 60 day notice will delay the receipt of retirement benefits. Proper notice shall consist of providing a signed retirement application on a Company approved form to the local Human Resource Department. Upon acceptance of the signed retirement application the employee will be scheduled to retire on their requested date.

In the event that an employee wishes to rescind their retirement application they must formally make this request in writing. The Company will consider the employee's request to rescind and will inform the employee of the Company's decision. The Company is under no obligation to approve the request to rescind.